

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Theodossia (NMI) Abramides		2a. DATE OF DEATH MONTH DAY YEAR 3-16-85		2b. HOUR 9:15A.M.	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 27, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Turkey	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN-HOSPITALITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13. STATE Maryland		13a. CITY OR TOWN Silver Spring	13b. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 2301 Glen Allen Avenue 20906
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Kirpoglou		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Son) ADDRESS 2301 Glen Allen Takis Abramides Ave, Silver Spring	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1972</u> to <u>March 15, 1985</u> , that (I) (we) lost the deceased alive on <u>March 15, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John J. Merendino</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John J. Merendino		22e. ADDRESS 11620 Kemp Mill Road, Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 19, 1985		23c. NAME OF CEMETERY OR CREMATORY Cypress Hills	
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn New York		23e. DATE REC'D. BY REGISTRAR MAR 20 1985			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE <u>Walter J. [Signature]</u>			

MEDICAL CERTIFICATION

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U. S. DEPARTMENT OF AGRICULTURE

NO. 1234

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARIE ELLEN ADAMS			2a. DATE OF DEATH MONTH DAY YEAR MARCH 7 1985		2b. HOUR MIN 7:39
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 31 10		6. AGE (IN YEARS LAST BIRTHDAY) 74	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J Walsh		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie E O'Leary		13e. STREET ADDRESS 5001 Russett Road 20853	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 014-16-1422		17. INFORMANT ADDRESS Joan Pharr 5001 Russett Rd. Rockville, Maryland 20853	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Obstructive pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 1 day - 3 days
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Diabetes**

19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from Feb 22 1985 to 3/7 1985 , that (we) last saw the deceased alive on Feb 22 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
22b. SIGNATURE Ira Kretzing	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/7/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Kretzing		22e. ADDRESS 2101 Med Park Dr Silver Spring 20902	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 3/7/85	23c. NAME OF CEMETERY OR CREMATORY Georgetown Univ. Med. School Washington, D.C.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services, Inc.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR Mar 13 1985	
225 Missouri Ave., N.W. Washington, D.C. 2001			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 provides retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, above, any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR				2b HOUR	
Sadie R. Akers						March 4, 1985				3:25pm	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Caucasian		Oct. 12, 1888		96 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		United States				Montgomery County MD.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Gaithersburg		Wilson Health Care Center						Homemaker		own home	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Gaithersburg				40 Russell Ave., zip 20878-20760			
14 FATHER'S NAME FIRST MIDDLE LAST				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Benjamin L. Rucker				Sally Parks							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT							
no		214 46 6599		Alexandria, Va. 22311 W.Scott Macgill, 4800 Fillmore Av., #928							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Residue of C.U.A.											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 19 72 to March 4, 1985, that (I) (we) last saw the deceased alive on Feb. 25, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.											
22b SIGNATURE Jack Schumacher M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3.5.85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher				22e ADDRESS 105 Russell Ave., Gaithersburg							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE					
Burial		Mar. 8, 1985		Rockville Cemetery		Rockville Maryland					
24 FUNERAL DIRECTOR NAME				25a DATE REC'D. BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland				MAR 8 1985				John Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work," any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Frances K. Alcorn			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1985			2b. HOUR pm 11:55				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 17, 1903		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY Meat Brokerage		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4400 East-West Highway #632 Zip: 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Frank J. Krammer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary R. Pohl							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Rev. James K. Alcorn, Son, 9600 S. Gessner, Houston, Texas 77071					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Perforated Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GI bleeding, ASTHMATIC BRONCHITIS										
19a. DATE OF OPERATION 3/9/85			CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED COLON			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 3/24 19 85 , saw the deceased alive above, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)										
22b. SIGNATURE Ralph M. Coan M.D.			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 25, 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ralph M. Coan, M.D.			22e. ADDRESS 4400 East-West Highway Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND					25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RUTH LYDIA ALLEGAR			2a. DATE OF DEATH MONTH DAY YEAR 3 10 85			2b. HOUR 1:55 A.M.					
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 24, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11013 Amherst Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11013 Amherst Avenue 20902			
14 FATHER'S NAME FIRST MIDDLE LAST John Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia McMahon							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 158-10-7509		17 INFORMANT ADDRESS George W. Allegar - Husband same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction - diffuse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic disease - primary</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>adenocarcinoma of the colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (the hospital) attended the deceased from <u>6/7/85</u> , 19 <u>85</u> , to <u>3/9</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/9</u> , 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR. JOSEPH SOLINAS FOR DR. DRAHER						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Solinas MD						22e. ADDRESS 9801 GEORGIA AVE. S.S. MD. 20902					
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE MARCH 12, '85		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE John Davidson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Bernice T. Alva		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 3 YEAR 26 1985		2b. HOUR M 00	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 15, 1918	6. AGE (IN YEARS) (LAST BIRTHDAY) 66 YRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 26 1985	7d. HOUR M 00
7a. BIRTHPLACE (STATE OR COUNTY) CALIFORNIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MARYLAND		12b. COUNTY MONTGOMERY		12c. CITY OR TOWN SILVER SPRING	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 410 TORRINGTON PLACE		13c. ZIP CODE zip---20901	
14. FATHER'S NAME FIRST MIDDLE LAST PHILLIP TUCKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER BARCOFF		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 579-10-9384		17. INFORMANT JEFF ALVA, 201 NEWBERRY STREET, JAMESTOWN, NORTH CAROLINA		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 1:58 P.M. 3 26 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto-fixed object impact	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 300 Blk. Franklin Ave, SilverSpring, Mont, MD.	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Thomas D. Smith</i>		TITLE (SPECIFY) M.D. Acting Chief		DATE SIGNED 3/28/85	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/29/1985		23c. NAME OF CEMETERY OR CREMATORY DISTRICT OF COLUMBIA LODGE CEMETERY	
23d. LOCATION COUNTY STATE WASHINGTON D. C.		23e. DATE REC'D. BY REGISTRAR APR 1 1985		23f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

098203

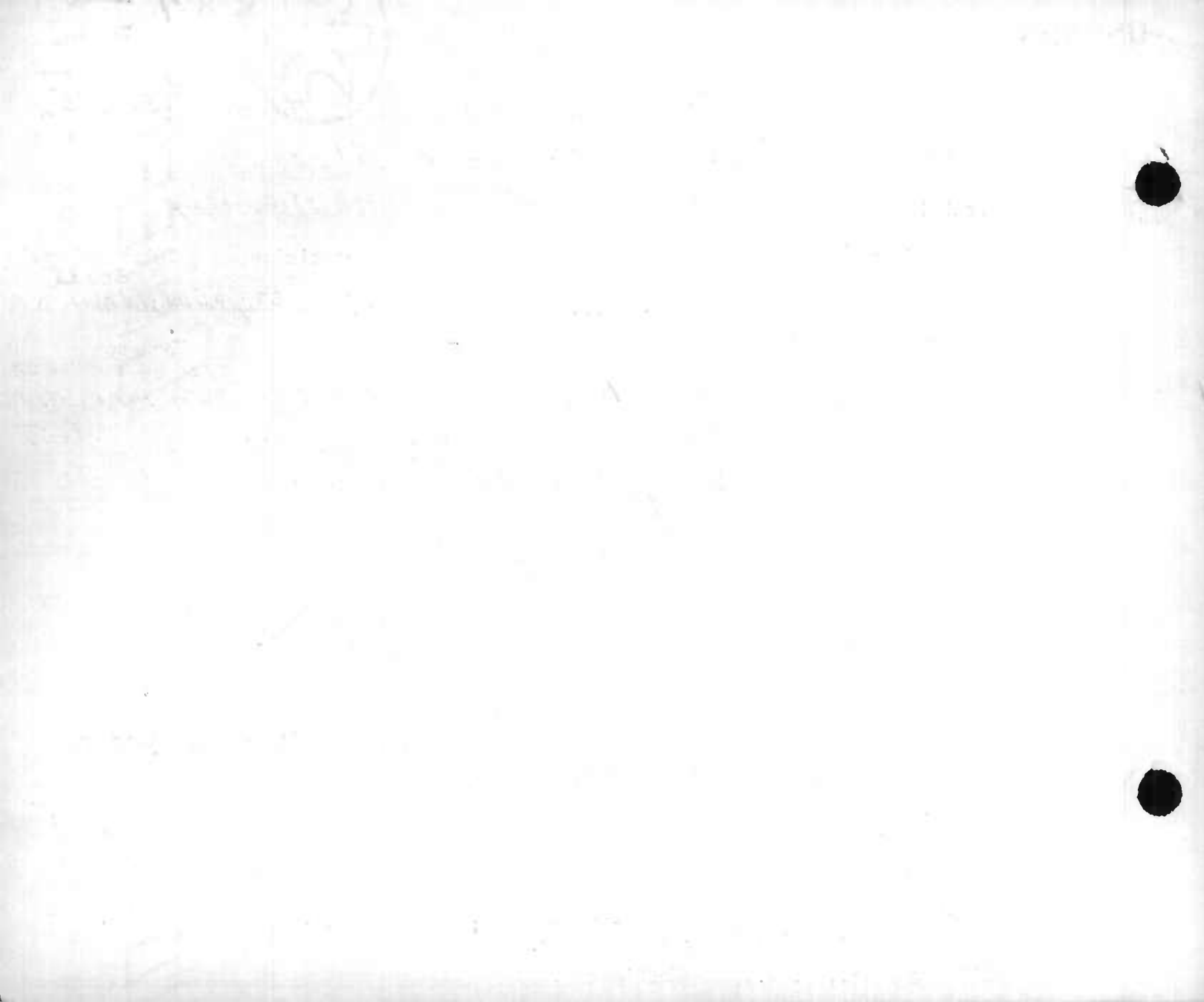
08751

088098

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY T. LAST ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR MARCH 15-85		2b. HOUR 5:45 P.M.		
3. SEX FEMALE		4. RACE BL		5. DATE OF BIRTH MONTH DAY YEAR 5-14-00		6. AGE (IN YEARS LAST BIRTHDAY) 84 Y.0 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BETHESDA HEALTH CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician		12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
13a. STATE WASH. D.C.		13b. CITY OR TOWN none		13c. CITY OR TOWN Wash., D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thornton Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Thompson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-32-1862A	
17. INFORMANT ADDRESS 5721 GROSVENOR LA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 3-15-85		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		Lungs	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from above, (I) (did) (did not) view the body after death.		21h. SIGNATURE DEGREE 3-15-85	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) THOS G. WARD		22b. ADDRESS 616 ROBINWOOD, Bethesda 20817		22c. DATE SIGNED 3/15/85		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-20-85		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.	
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home, Inc.		24b. ADDRESS 4217 9th St., N.W., Washington, DC		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



093025

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Vivian Joyce Apicella</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3 26 85</i>		2b. HOUR <i>6:56 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Wh</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>8 05 32</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>GEORGIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>52</i> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>ROCKVILLE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>13411 ARCTIC AVENUE</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont. Co.</i> MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Health Aide</i>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <i>MD</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>ROCKVILLE</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>CHARLES WOODARD BROWNING</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DOROTHY ELLEN THOMAS</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>256-48-0713</i>		17. INFORMANT ADDRESS <i>Husband - Michael Apicella</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

metastatic lung cancer

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*9 months*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>2-27</i> 19 <i>80</i> , to <i>3-26</i> 19 <i>81</i> , that (1) (we) lost saw the deceased alive on <i>3-20</i> 19 <i>85</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>James Brodsky MD</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3-27-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Brodsky MD</i>		22e. ADDRESS <i>4701 Wilford Ave Chevy Chase</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>3/30/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Falls Church, Fairfax, VA</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>MURPHY FUNERAL HOME FALLS CHURCH 1102 W. Broad St. Falls Church, Virginia</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 02 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

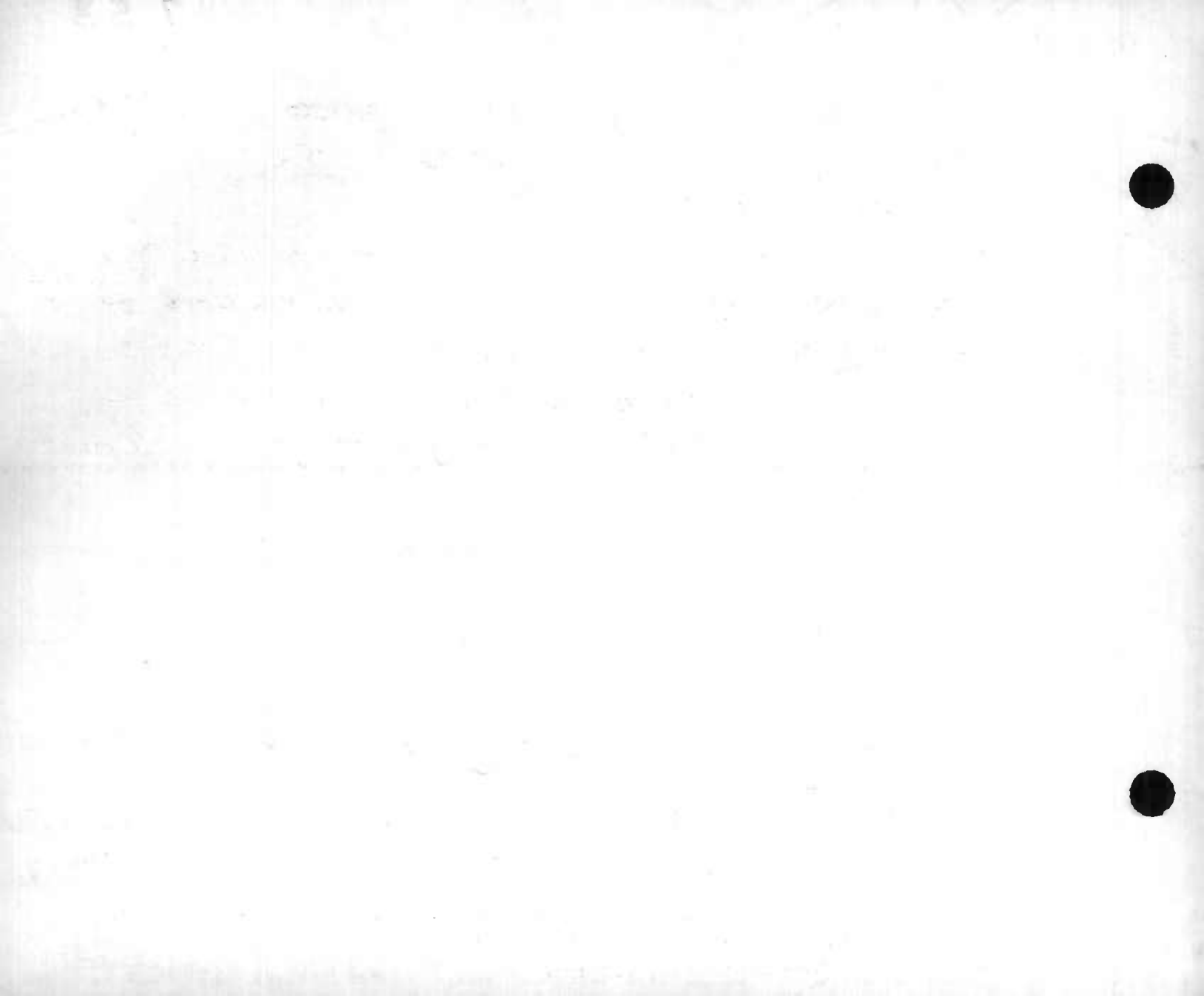
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

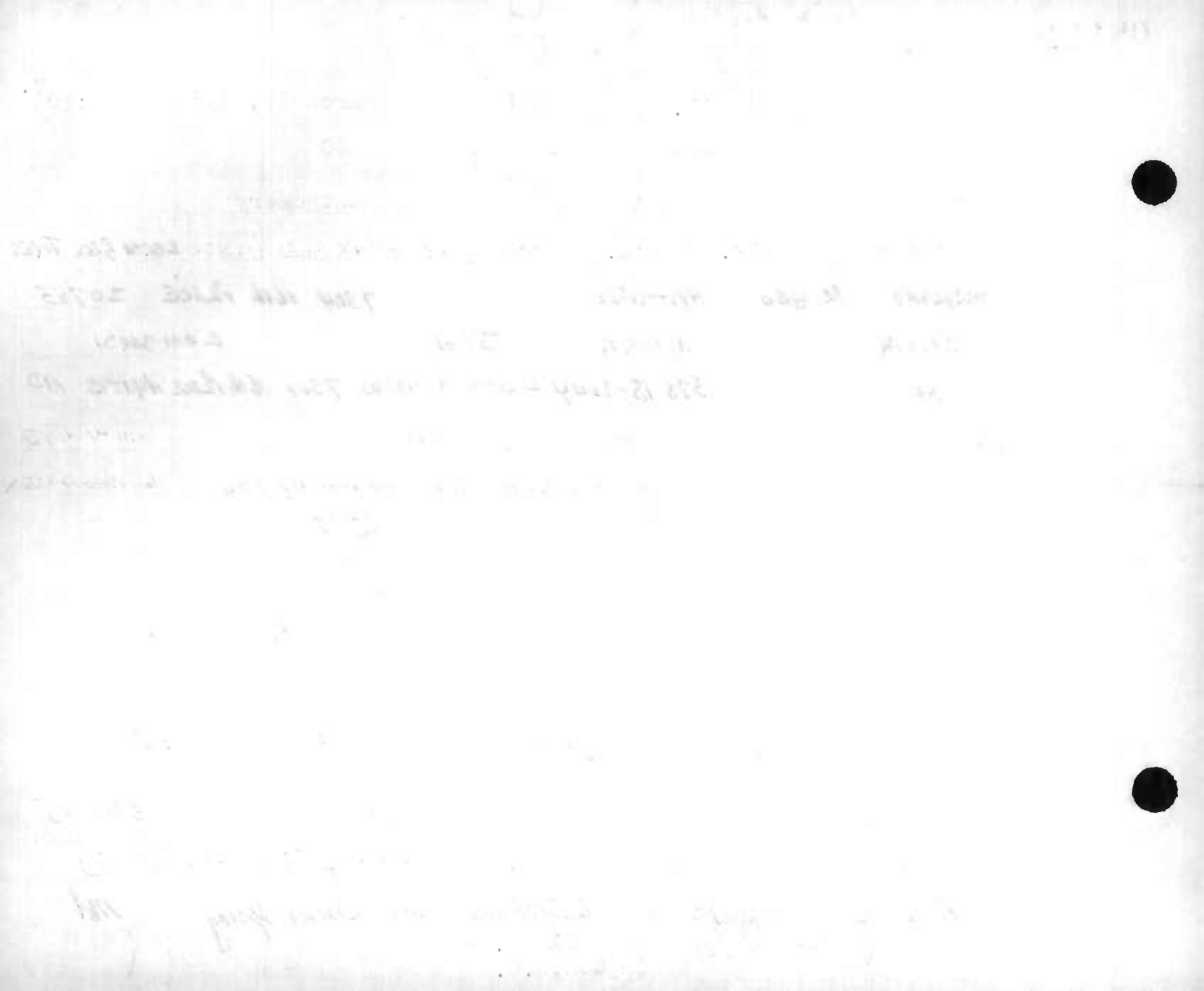
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P.
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		March 17, 1985		6:30 P.M.
Thomas L. Apperti								
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
Male	Caucasian	Feb., 28, 1905		80		MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Canada		U S A				Montgomery MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Wheaton		Univ. Conval. & Nursing Home		TIRE SALES MANAGER		LEETH BROS TIRES		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE				
13a. STATE		13b. YES <input type="checkbox"/> NO <input type="checkbox"/>		7304 16th PLACE		20783		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
FIRST		LAST		FIRST		MIDDLE		LAST
JOSEPH		APPERTI		JEAN		L O M B A R D I		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		
No		578-18-7244		LORETTA A. ADAMS		7304 16th PLACE HYATTS. MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		respiratory arrest.		immediate		
DUE TO, OR AS A CONSEQUENCE OF		(b)		Small cell carcinoma of the lung		6 months		
DUE TO, OR AS A CONSEQUENCE OF		(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1976, 19, to 3/17, 1985, that (I) (we) last saw the deceased alive on 3/11, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE		DEGREE		22c. DATE SIGNED				
Deborah B Goldberg		MD		3/18/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Deborah B Goldberg		1106 Spring St, Silver Spring						
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		March 21, 1985		Date of Heaven Cem.		Silver Spring MD		
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Takoma Funeral Home		54 Carroll St. NW Washington, D.C.		MAR 20 1985				



088099

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8755
REG. NO.

1- FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS MONTH DAY YRS.)		7a. BIRTHPLACE (STATE OR FOREIGN (UNIT))		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		7c. DATE OF DEATH (MONTH DAY YEAR)		7d. HOUR	
		ANNIE JANE ARMSTRONG				F		Black		unknown		90		unknown		unknown		Montgomery		March 17, 1985		2:32 PM			
		Takoma Park		Washington Adventist Hospital		retired																			
		MD		MONT		Takoma Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8016 Garland Ave., #303															
		unknown		unknown		unknown																			
		unknown		238 12 4700		Annie Bennett		unknown																	
		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Advanced Arteriosclerosis</u>		DUE TO, OR AS A CONSEQUENCE OF		(b) <u>Cardiovascular Disease</u>		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
		ACTUAL SIGNATURE <u>Richard L. Whelton</u>		TITLE (SPECIFY) <u>Deputy</u>		DATE SIGNED <u>March 17, 1985</u>																			
		EXAMINER'S NAME (TYPE OR PRINT) <u>RICHARD L. WHELTON</u>		ADDRESS <u>7100 Balt Ave College Park MD</u>																					
		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		23b. DATE <u>Mar/19/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Farmville, NC</u>																	
		24. FUNERAL DIRECTOR NAME <u>RN Horton</u>		ADDRESS <u>600 Kennedy St. NW WashDC</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 22 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Lia Davidson-Randall</u>																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) David D. Arnold				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3/31 19 85				2b. HOUR 7:59 A.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 9, 1969	6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3/31 19 85	7d. HOUR 7:59 A.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9507 Curran Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 9507 Curran Road 20901				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BURROWES ARNOLD, JR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PATRICIA ANN CRIPPEN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS PATRICIA ARNOLD, MOTHER, SAME AS ITEM #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute leukemia. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None										
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 4/1/85		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4/4/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA			
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC.				ADDRESS 1804 T ST., N.W., WASHINGTON, D.C. 20009			25a. DATE REC'D. BY REGISTRAR APR 8 1985		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

101013

White Mar. 2, 1969 10

Montgomery

Silver Spring 9907 Curran Road

Montgomery Silver Spring 9907 Curran Road 20002

House location.

None

None

None

X

X

John S. Roberts, M.D.

191, Seminary Road
Silver Spring, Montgomery, Md.
4/1/68

100 T ST., N.W., WASHINGTON, D.C. 20002
RICHARD HART, INC.
WASHINGTON, D.C.

098187

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel ETHEL K. K ARTIGIANI			2a. DATE OF DEATH MONTH DAY YEAR 3 23 85			2b. HOUR 1330 PM			
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 3 08		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUMMIT COUNTY, GIVE STREET ADDRESS) SHADY GROVE HOSPITALIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4630 Han Court Road 4214	
14. FATHER'S NAME FIRST MIDDLE LAST John Knox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Pecher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-32-0151		17. INFORMANT ADDRESS 9406 Quill Place Gaithersburg			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Hypertension & aortic DUE TO, OR AS A CONSEQUENCE OF (c) Symptoms with antyprist to abdomen PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension, Septicemia, Bacteremia & blood									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/13 19 85 , to 7/23 19 85 , that (I) (we) lost saw the deceased alive on 3/13 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ruben C. Casca DEGREE M.D.						22c. DATE SIGNED 3/23/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN C. CASCA						22e. ADDRESS 1524 MEDLAND ROAD DEANWOOD, MD 20855			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/26.1985		23c. NAME OF CEMETERY OR CREMATORY St. Francis Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gettysburg, Pa.		
24. FUNERAL DIRECTOR NAME Ruben C. Casca						25a. DATE REC'D. BY REGISTRAR APR 01 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified.

BP



1. The first part of the document is a list of names and addresses. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column. The text is somewhat faded and difficult to read.

2. The second part of the document is a large, rectangular area containing a grid of small, handwritten notes. The notes are written in a cursive script and are organized into rows and columns. The grid is approximately 10 rows by 10 columns. The text is very faint and difficult to read.

3. The third part of the document is a list of names and addresses, similar to the first part. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list is organized into columns, with names in the first column and addresses in the second column. The text is somewhat faded and difficult to read.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
JANET WINNIFRED AULT		3 20 85		10 ⁰³ P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
FEMALE	CAUCASIAN	MONTH DAY YEAR	67 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MASSACHUSETTS	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	10308 RIDGEMOOR DRIVE		NURSE		REGISTERED NURSE
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND	MONTGOMERY	SILVER SPRING	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10308 RIDGEMOOR DRIVE 20901	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
WALTER CHABER		JULIA SUDOL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
YES		WW II	RAY C. AULT SAME AS 13 HUSBAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) LIVER METASTASIS					1 YEAR
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
(b) CARCINOMA LEFT BREAST					27 YEARS
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/20 19 82, to 3/20 19 85, that (I) (we) lost saw the deceased alive on 3/19 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Hubert J. Albert MD		MD		3/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Hubert J. Albert MD		8630 FENTON ST #230 Silver Spring MD 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
BURIAL		3/23/85	GATE OF HEAVEN		CITY OR TOWN COUNTY STATE
					SILVER SPRING MONT MD.
24. FUNERAL DIRECTOR		25a. DATE REG. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		APR 26 1985			
FRANCIS J. COLLINS					
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

65184

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1- FOR
STATE
REGISTRAR

REG. NO.

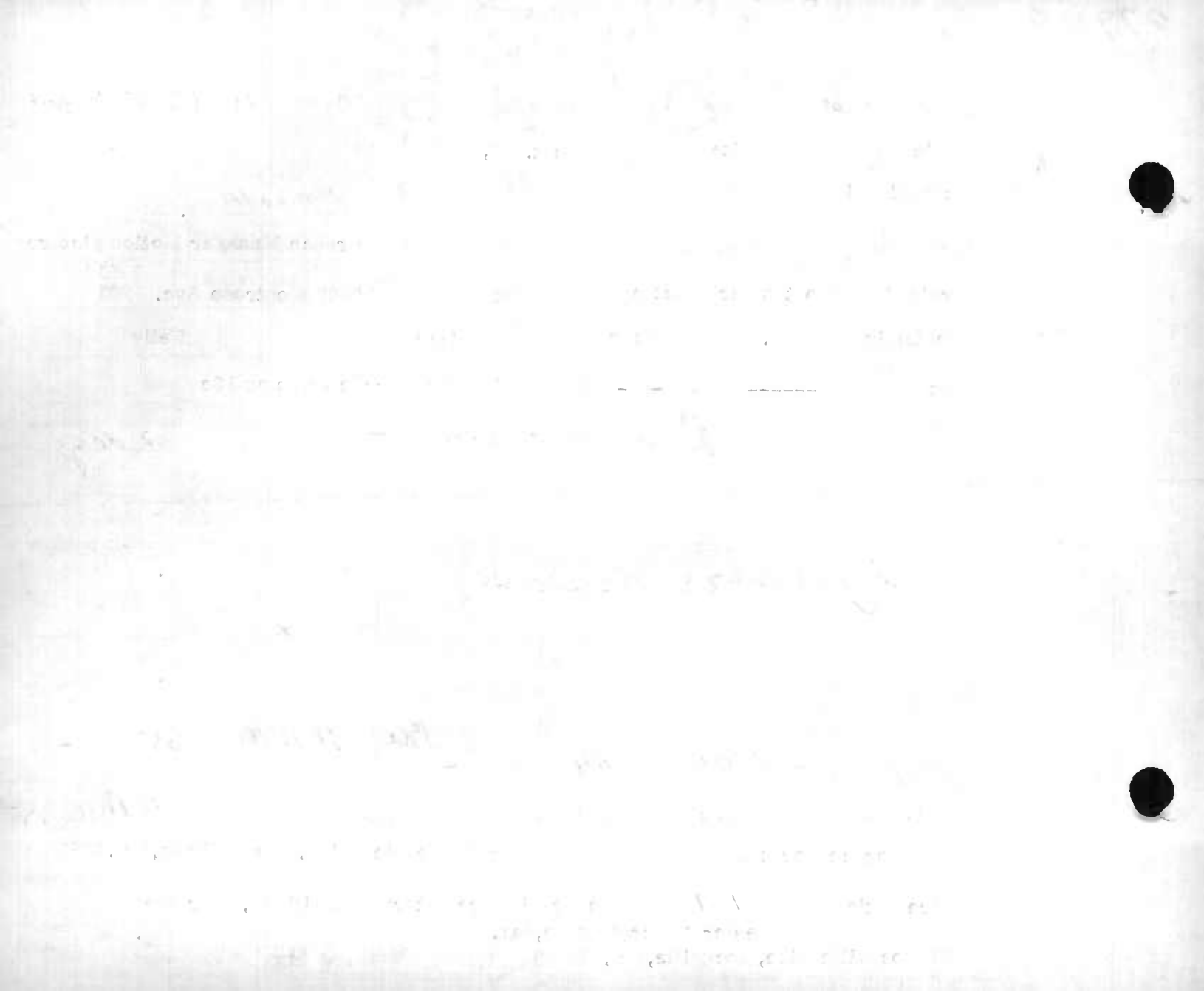
1. DECEASED NAME (TYPE OR PRINT) Benjamin F Bache			2a. DATE OF DEATH MONTH DAY YEAR Mar 11, 1985		2b. HOUR 7:50 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 26, 1906	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Bethesda MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Branch Manager	12b. KIND OF BUSINESS OR INDUSTRY Motion pictures	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME Benjamin F. Bache			15. MOTHER'S MAIDEN NAME Alice Kelly		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 176-03-4536	17. INFORMANT ADDRESS Emily Chell Bache same as 13c		
18. CAUSE OF DEATH (Enter only one cause per item (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia — DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alzheimer's disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 19 1960 to 11 Mar 19 85, that (I) (we) lost the deceased alive on 11 Mar 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Horace Bernton		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11 Mar '85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Horace Bernton		22e. ADDRESS 4743 Bradley Blvd. Chevy Chase, Md. 20815			
23a. BURIAL, CREMATION, REMOVAL SPEC Cremation	23b. DATE 3/12/85	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION Suitland, Maryland STATE		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 st Rockville Pike, Rockville, Md. 20852			25a. DATE REC'D. BY REGISTRAR MAR 15 1985		
			25b. REGISTRAR'S SIGNATURE John Davidson-Hendall		

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.



088132

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

08760

1. DECEASED NAME (TYPE OR PRINT) Leah S. Bain			2a. DATE OF DEATH MONTH 3 DAY 19 YEAR 1985			2b. HOUR 8³⁵ AM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH Dec. DAY 13 YEAR 1897		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10000 Brunswick Av. / 20910	
14. FATHER'S NAME FIRST Frank MIDDLE Stuart LAST Stuart			15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE A. LAST Not Available			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. 220 44 5770			17. INFORMANT Bethesda, Maryland Kurt H. Kloetzer, 10681 Weymouth St.,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) overwhelming respie with doc DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) retroperitoneal abscess DUE TO, OR AS A CONSEQUENCE OF (c) supratentorial cerebral carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 days 5 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no									
19a. DATE OF OPERATION 3-18-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Retroperitoneal abscess				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/18/85 to 3/19/85 , that (I) (we) lost 3/18/85 above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel Powers M.D. DEGREE MD								22c. DATE SIGNED 3-19-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL POWERS M.D.				22e. ADDRESS 50 W EDMONDSON DR. ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 22, 1985		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Funeral Homes, P.A. Bethesda, Maryland.				25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Sally A. Baitty						2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 3/6 19 85		2b. HOUR 9:40 pm			
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR June 8, 1916	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 3/6 19 85		2d. HOUR 9:40 pm			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b. KIND OF BUSINESS OR INDUSTRY City Gov't				
13a. STATE Florida		13b. COUNTY Sarasota		13c. CITY OR TOWN Sarasota		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 800 Benjamin Franklin Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Diaz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Otero		16. ADDRESS Potomac, MD.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234 10 6032		17. INFORMANT Robert L. Baitty-11125 Hurdle Hill Drive							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: Coronary arteriosclerosis. (b) Coronary arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER		DATE SIGNED 3-6-85 md. 20895			
EXAMINER'S NAME (TYPE OR PRINT) John Tauber			ADDRESS 8218 Wisconsin ave Bethesda								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 7 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia				
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, Virginia			ADDRESS MAR 08 1985								

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completedly filled in by the funeral director, pages 3 and 4 should be placed in the body of the casket. Pages 1 and 2 should be filed with the local health department or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event to the medical examiner must be identified at once.

MEDICAL CERTIFICATION

1

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8508762 REG. NO.							
2 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MATTHEW J. BARTOL						2a DATE OF DEATH MONTH DAY YEAR March 7, 1985				2b HOUR MIN 4:25 M			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR March 12, 1911		6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10 CITY OR TOWN OF DEATH TAKOMA PARK		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN (RET.)			12b KIND OF BUSINESS OR INDUSTRY D.C. MET.				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD. COUNTY MONT CITY OR TOWN TAKOMA PARK						13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c STREET ADDRESS / ZIP CODE 7115 POPLAR AVENUE 20917					
14 FATHER'S NAME FIRST MIDDLE LAST MATT BARTOL				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANTONIO DEBELAK									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-09-4278		17 INFORMANT ADDRESS BRUCE M. BARTOL, MIDDLETOWN, MD. 21764									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebellar hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coumadin anticoagulation DUE TO, OR AS A CONSEQUENCE OF (c) stroke										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours 2 weeks 3 weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> #1 WORK #2 WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) this hospital attended the deceased from May 19 84, to March 7 19 85, that (I) (we) last saw the deceased alive on March 7 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (and not) see the body after death.													
22b SIGNATURE Mark S. Rosen MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 3/8/85					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Mark S. Rosen, MD				22e ADDRESS Silver Spring, MD									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION CITY OR TOWN COUNTY STATE Burial March 12, 1985 Union Cemetery Burtonsville Mont MD					
24 FUNERAL DIRECTOR NAME Takoma Funeral Home				24b ADDRESS 754 Carroll St NW				25 DATE REC'D. BY REGISTRAR MAR 11 1986				25b REGISTRAR'S SIGNATURE J. Davidson-Randall	

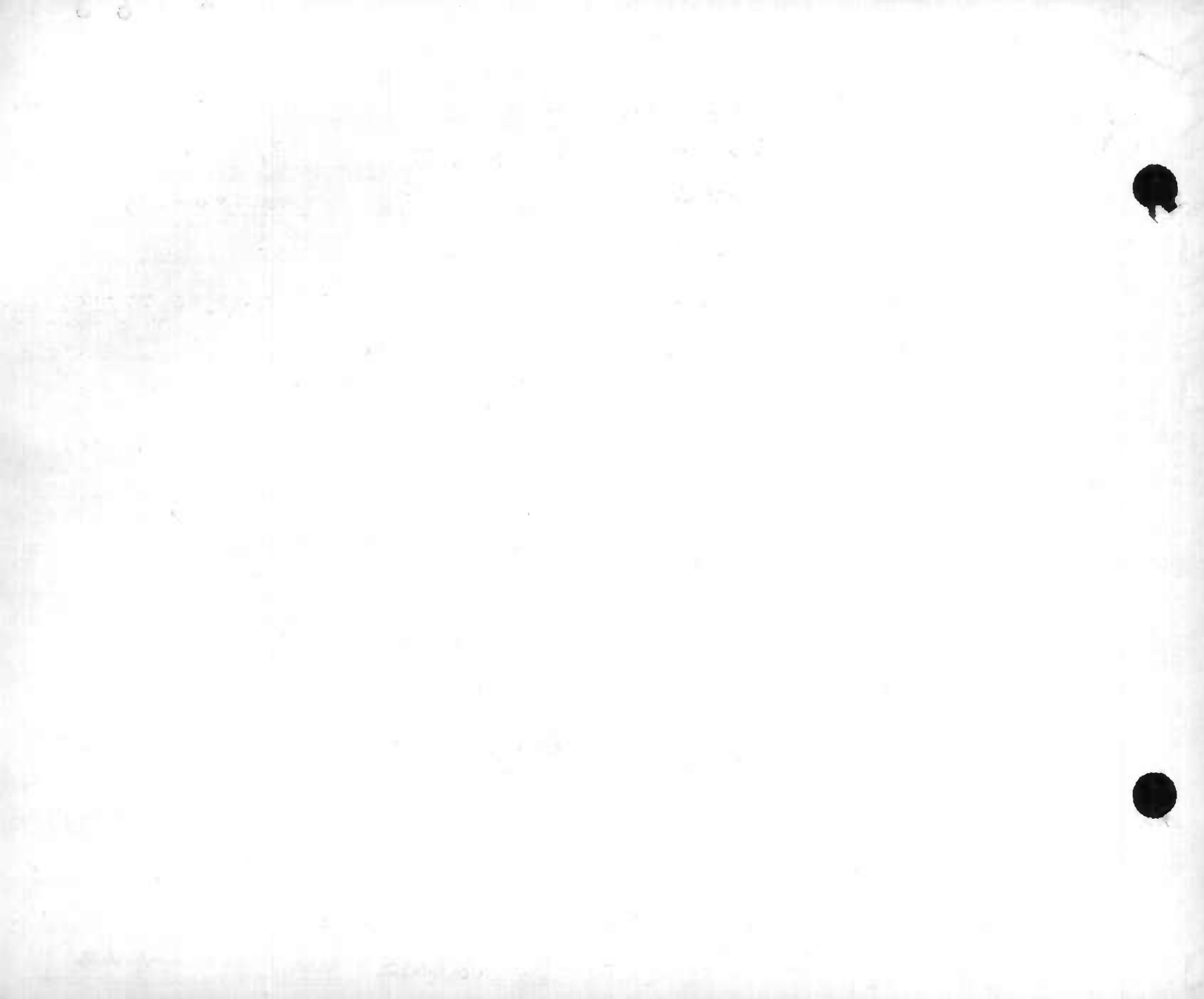
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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BRADFORD W. BATER			2a. DATE OF DEATH MONTH DAY YEAR 3 16 85			2b. HOUR 64m		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 8 4 53		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH Montgomery		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Officer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE District of Columbia			13b. CITY OR TOWN Washington		13c. STREET ADDRESS / ZIP CODE 3755 Minnesota Avenue, N.E.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Bates			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clementine Foster					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 578 70 6743		17. INFORMANT ADDRESS Mrs. Clementine Bates-mother-3755 Minnesota Avenue, N.E., Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/15/84</u> 19 <u>85</u> to <u>16/16/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>15/16/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Michael Leibowitz, MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 16/16/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, MD			22e. ADDRESS 1120 New Hampshire Ave SE, NE 20904					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 23, 1985		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md	
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Road			25a. DATE REC'D. BY REGISTRAR APR 28 1985			25b. REGISTRAR'S SIGNATURE John Davidson-Randall		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 8 / 6 4					
1- FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) GLADYS BOYD BAUER				2a. DATE OF DEATH MONTH DAY YEAR MARCH 21 1985				2b. HOUR 5:40P ^M	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 26 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Free Lance		12b. KIND OF BUSINESS OR INDUSTRY Advertising	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA				13b. COUNTY FAIRFAX		13c. CITY OR TOWN MCLEAN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H BOYD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELIA NMN JOHNSON				13e. STREET ADDRESS / ZIP CODE 6251 OLD DOMINION DR. 264 22101	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NO		17. INFORMANT ADDRESS EMILIE BAUER BEHRENS, 116 East Dudley Ave. WESTFIELD, NJ 07090		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAR 19, 1985, to MAR 21, 1985, that (I) (we) lost saw the deceased alive on MAR 21, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) verify the body after death.				22b. SIGNATURE E. S. Killeavy M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 25 Mar 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE S. KILLEAVY, M.D.				22e. ADDRESS 20814 NAVAL HOSPITAL BETHESDA, NMC NCR, BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 27 1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia			
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, Va.				25a. DATE REC'D. BY REGISTRAR MAR 29 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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UNION MARK-TRADE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LEONA FREDERICKA BEAVERS			2a. DATE OF DEATH MONTH DAY YEAR 3 11 85			2b. HOUR 42 M	
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR APRIL 15, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE MARYLAND		13b. COUNTY PR. GEO.		13c. CITY OR TOWN LANGLEY PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick W. Schnabele				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Van Horn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-6909		17. INFORMANT ADDRESS Nathan F. Beavers-Husband same as # 13			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pericardial Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left Heart</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-3 hrs</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>24 yrs</u>							
19a. DATE OF OPERATION <u>2/22/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Myocardial Infarction</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from <u>3/11/85</u> to <u>3/11/85</u> , that (I (we)) last saw the deceased alive on <u>3/11/85</u> , and that (my (our)) opinion death occurred on the date and hour and from the causes stated above. (I (we)) (did) (did not) view the body after death.							
22b. SIGNATURE <u>H. L. MARTER</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/11/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. MARTER		22e. ADDRESS <u>6700 Conall Ave Takoma Park MD</u>					

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE March 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland	
24 FUNERAL DIRECTOR NAME Francis J. Collins 500 University Blvd. West S.S., Md. 20901				25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE <u>Lia Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Roland		FRANK	Beers, Jr.	3-20-85		9:17				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
male	white	3 31 23	61 YRS.			3 20 85				9:17
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York	U.S.A.				Montgomery		MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda	Suburban Hospital			Physician		Medicine				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
MD	Montgomery	Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5123 Dudley Lane/20814					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
Roland F. Beers				Helen Clark						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes				Korea		Unknown				
						burg, VA				
						James Beers, 240 N. Broadway St, Williams-				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) _____
CONDITIONS, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____
DUE TO, OR AS A CONSEQUENCE OF

cardiac arrest

acute Respiratory failure

acute asthmatic attack

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John Tauber		M.D. Deputy		3-20-85	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BETHESDA MD.	
John Tauber		8218 WISCONSIN AVE			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	3/23/85	Cedar Hill Crematory	Suitland, Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR	
Joseph Gawler's Sons, Inc.		MAR 28 1985	
5130 Wisconsin Ave, NW, Washington, D.C. 20016		25b. REGISTRAR'S SIGNATURE	
		John Tauber	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 177 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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DHMH - 17
(VR A15 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

680420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

082128

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GENEVIEVE M. BEHRENS			2a. DATE OF DEATH MONTH DAY YEAR MAR 1 85		2b. HOUR 7³⁰ AM
3. SEX FEMALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 10 19 08	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) EUROPE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONT MD		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Esunas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Theresa UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-05-4660	17. INFORMANT ADDRESS Carlton R. Behrens Husband Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute renal failure DUE TO, OR AS A CONSEQUENCE OF (b) malignant hypertension DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 PM 19 85	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21a. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.)	21i. LOCATION STREET 7 YRS	CITY OR TOWN 9/1	COUNTY 85	STATE
22a. I certify that (I) (this hospital) attended the deceased from 7 YRS 19 85 to 9/1 19 85 , that (I) (yes) last saw the deceased alive on 3-1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE Robert Kramer			DEGREE MD	22c. DATE SIGNED 3-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER			22e. ADDRESS 10313 Georgia Ave 880d.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 5, 1985	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d. LOCATION (CITY OR TOWN) COUNTY STATE Washington, D. C.		
24. FUNERAL DIRECTOR NAME Francis J. Collins			25a. DATE REC'D. BY REGISTRAR MAR 7 1985		
ADDRESS 500 University Blvd., W. Silver Spring, Md.			25b. REGISTRAR'S SIGNATURE L. J. ...		

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20% OFF
WINTER
20% OFF

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1981-29-072
1981-29-072

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1981-29-072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Beatrice Stern Beller</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Mar 7, 85</i>			2b. HOUR <i>8:20 AM</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 8, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>YRS.</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Home of Greater Washington</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary (Ret.)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Chemical Co.</i>			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>10800 Georgia Avenue, #10T 20905</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alexander Stern</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Fannie Rosenblum</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>079-26-5035</i>	
17. INFORMANT ADDRESS <i>William Beller; 2701 Largo Place; Bowie, Md. 20715</i>											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic colon carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____		

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 21</i> , 19 <i>85</i> , to <i>3/7</i> , 19 <i>85</i> , that (II) (we) lost saw the deceased alive on <i>3/5</i> , 19 <i>85</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Mark Rosen</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/5/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mark Rosen</i>		22e. ADDRESS <i>Silver Spring, MD</i>					

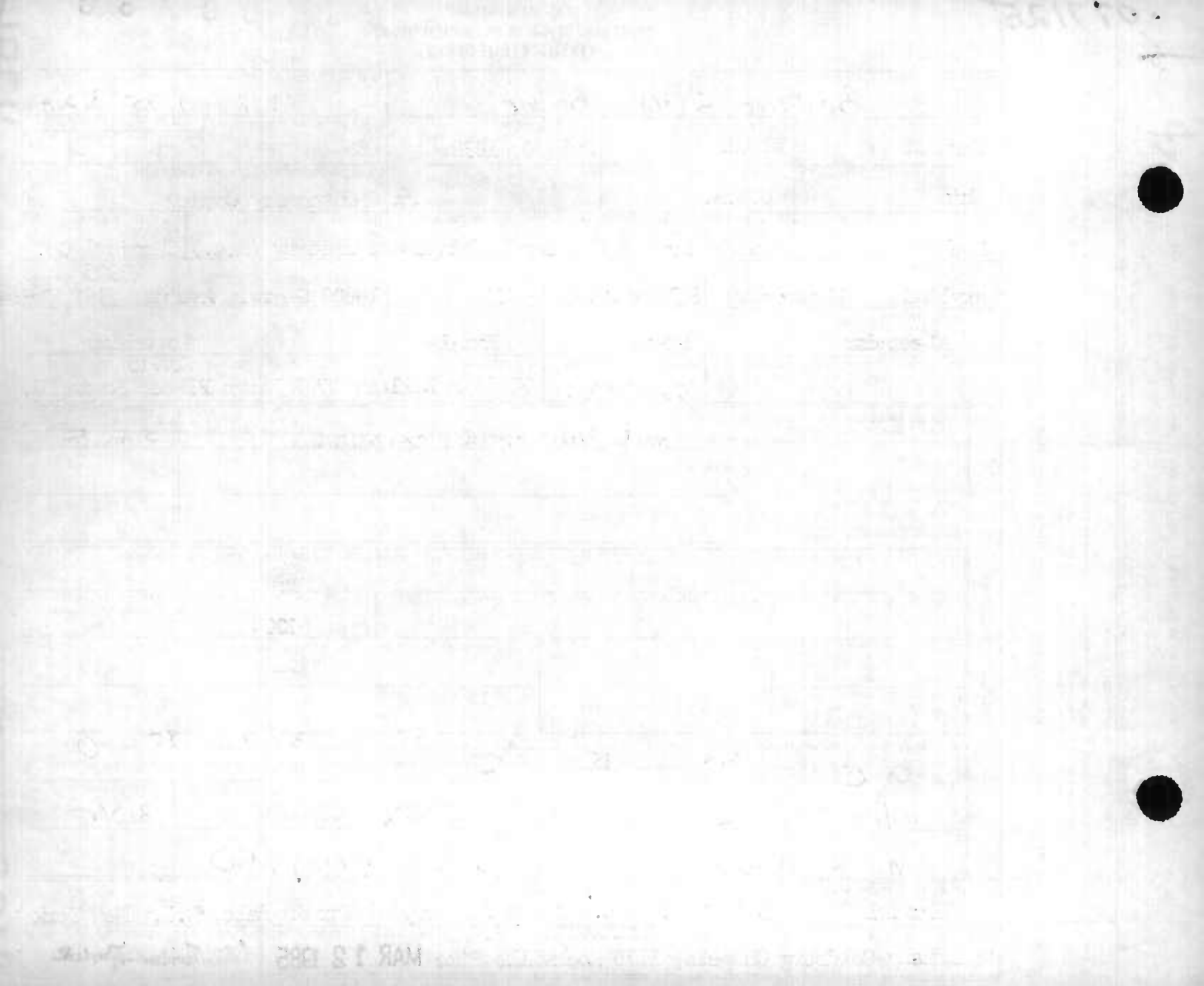
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-11-1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Ararat Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Farmingdale, L.I., New York</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 12 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, please only injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

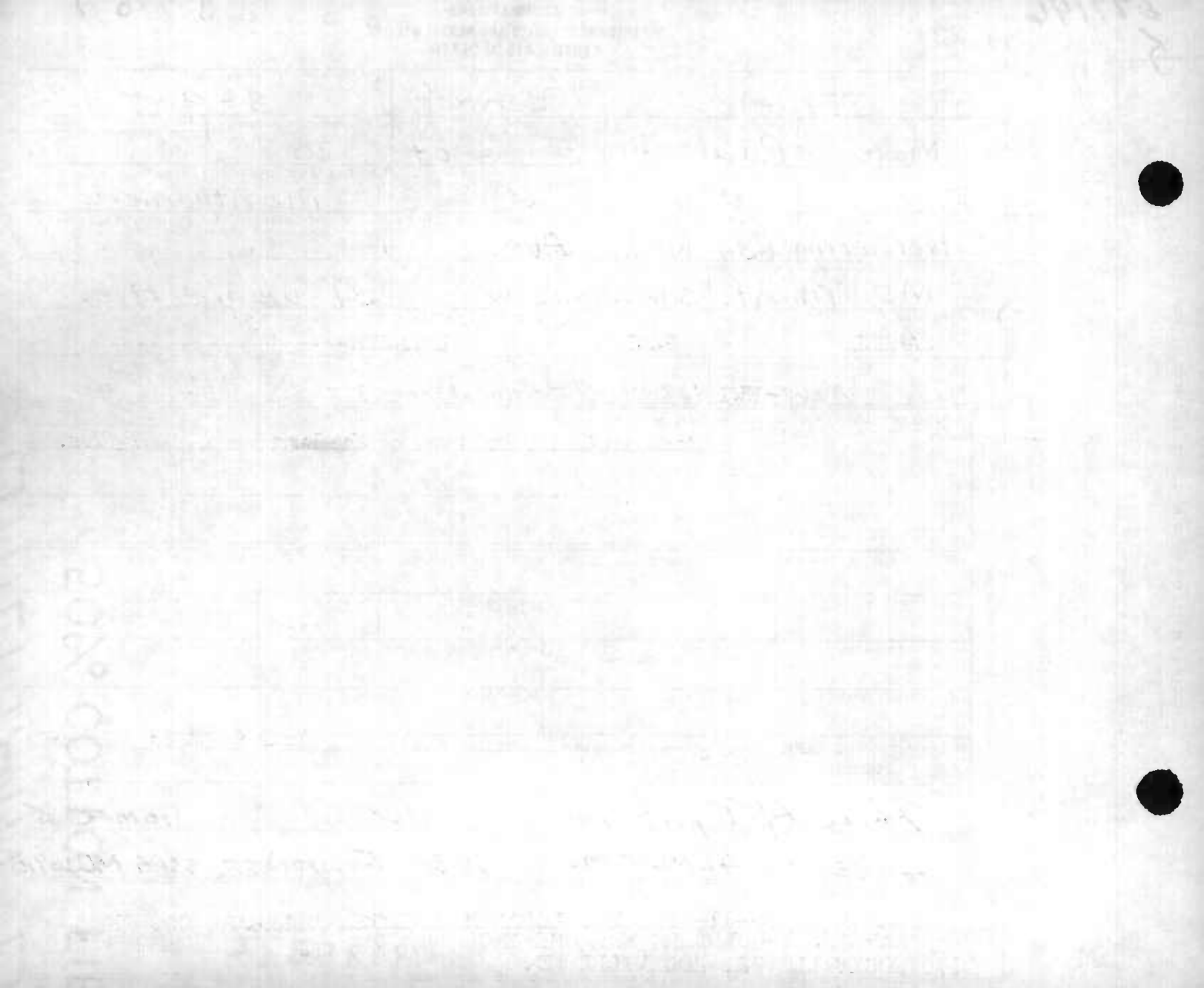
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
			FIRST MIDDLE LAST Israel Bennof		MONTH DAY YEAR 3-9-85	
3. SEX Male			4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3-23-04	
6. AGE (IN YEARS LAST BIRTHDAY) 80			7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia			7b. CITIZEN OF WHAT COUNTRY? U.S.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 634 Wayne Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Produce Buyer	
12b. KIND OF BUSINESS OR INDUSTRY Supermarket			13a. STREET ADDRESS / ZIP CODE 634 Wayne Ave.		13b. STREET ADDRESS / ZIP CODE 20855	
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL BENNOF			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16. SOCIAL SECURITY NO. 167-18-2734	
17. INFORMANT ADDRESS 634 Wayne Ave Silver Spring, MD			18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma of the Lung DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) XXXXXX attended the deceased from June 1, 1984, to March 9, 1985, that (I) XX lost saw the deceased alive on March 9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. XXXXXX (did not) view the body after death.						
22b. SIGNATURE Hubert J. Alpert, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10 MAR 85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT MD		22e. ADDRESS 8630 FENWON ST. SSPG MD 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-11-85		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEMETERY DELAWARE CO. PENN.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM CHP INC 1170 ROCKVILLE PK. ROCKVILLE MD.						
25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 13 1985						

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
JOSEPH R. BERGER			MARCH 28 1985			7 ¹⁰ P.M.				
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		
MALE	CAUCASIAN	JAN 23, 1912		73 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
CALIFORNIA		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
SILVER SPRING		1211 PINECREST CIRCLE		CLINICAL PSYCHOLOGIST						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND			MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1211 PINECREST CIRCLE 20910	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
SAMUEL N. BERGER			STELLA V. WAGNER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO			579-22-2604		VIVIAN L. BERGER		SAME AS 13		WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) HISTIOCYTIC LYMPHOMA								15 MONTHS		
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
			HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from SEPT 19 84, to MARCH 28 19 85, that (I) (we) lost saw the deceased alive on MARCH 28 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
MARTIN H. COHEN, MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			3/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
MARTIN H. COHEN					2611 Weller Rd Silver Spring MD 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL			4/1/85		FT. LINCOLN CEMETERY		BRENTWOOD PRI GEO MD.			
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME FRANCIS J. COLLINS					APR 1 1985		John Davidson-Randall			
500 UNIV. BLVD., W. SILVER SPRING, MD. 20901										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

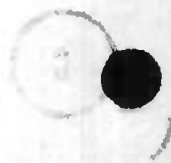
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, or medical condition that contributed to death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST yetta Bernstein				2a. DATE OF DEATH MONTH DAY YEAR 3-5-85	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-27-14	
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STREET ADDRESS / ZIP CODE 10606 Bucknell Drive; 20902		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Bernstein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida (Unknown)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (1) YES (2) NO (3) UNKNOWN NO	
16b. SOCIAL SECURITY NO. 089-18-7792		17. INFORMANT Maurice Bernstein; 10606 Bucknell Dr.; S.Spg., Md. 20902		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Vascular Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week 3 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2-28-85 to 3-5-85 , that (we) last saw the deceased alive on 3-5-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.					
22b. SIGNATURE Michael Leibowitz, MD		22c. DATE SIGNED 3-5-85		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, MD		22f. ADDRESS 1120 N. H. St. Md 20904			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/85		23c. NAME OF CEMETERY OR CREMATORY King David Memorial Gdn.; Falls Church; Fairfax; Va.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852					

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5/21/85 Item 13 L.J

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH M. BERRY			2a. DATE OF DEATH MONTH DAY YEAR MARCH, 15, 1985		2b. HOUR 2:50 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 - 26 - 04	6. AGE (IN YEARS/LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) O'Coon, Mo.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY —	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		
13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Washington Berry			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Duniken		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. —		
17. INFORMANT ADDRESS Rosa Butler 8919 Frank Lippett Rd. Cheltenham-Md. 20633					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) metastatic breast cancer DUE TO, OR AS A CONSEQUENCE OF (b) hepatic mets DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) organic brain syndrome					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19-193 to 3-14 19 85 , that (I) (we) last saw the deceased alive on 3-12 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. Bahar		DEGREE —		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR		22e. ADDRESS 8218 Wisconsin Ave Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/85		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Ch. Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Croon P.G.Md.		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
24. FUNERAL DIRECTOR NAME Matell Adams		ADDRESS Crookston Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination may be required by the funeral director. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



THE
OFFICE OF THE
ATTORNEY GENERAL
STATE OF NEW YORK
ALBANY
JANUARY 13, 1902
TO THE
COMMISSIONER OF THE
LAND OFFICE
SIR:
I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.

Very respectfully,
J. B. CROSSLAND
Attorney General
NOTED
JAN 15 1902
COMMISSIONER OF THE LAND OFFICE

083129

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. These pages must be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMPORTANT: If item 21 is marked or item 18 covers any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELENA BERTRAM					2a. DATE OF DEATH MONTH DAY YEAR HOUR 3 8 85 3:15 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. IF UNDER 1 YEAR (MONTHS) DAYS HOURS MIN.	
8. BIRTHPLACE (COUNTRY) Germany		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
12. CITY OR TOWN OF DEATH Olney		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURS. HOME				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		15. KIND OF BUSINESS OR INDUSTRY own home	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY Montgomery		16c. CITY OR TOWN Silver Spring		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE 3605 Tarkington Lane 20906	
17. FATHER'S NAME FIRST MIDDLE LAST Asmus Wilken Diekmann		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Hohmann							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE BRANCH AND DATE) N/A		19b. SOCIAL SECURITY NO. 578-50-1549		19c. INFORMANT ADDRESS Helen B. Wilhelm daughter-(same as 13e)					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b): DUE TO, OR AS A CONSEQUENCE OF: (c): Respiratory failure Congestive heart failure AGE 89									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus									
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		23b. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23c. LOCATION STREET CITY OR TOWN COUNTY STATE					
24. I certify that (1) (this hospital) attended the deceased from 4/1/84 to 3/8/85 , that (1) (last seen the deceased) on 3/7/85 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated									
25. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				26. DATE SIGNED 3/8/85	
27. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Lighty MD		28. ADDRESS 1811 Pt Philip Dr. Olney Md 20832							
29a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		29b. DATE Mar. 11, 1985		29c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery		29d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		29e. DATE REC'D. BY REGISTRAR	
30. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Sil Spr. Md.		31. DATE REC'D. BY REGISTRAR MAR 11 1985		32. REGISTRAR'S SIGNATURE [Signature]			

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Handwritten notes and calculations, including a large '2' and various numbers and symbols.

Handwritten notes and calculations, including a large '2' and various numbers and symbols.

Handwritten notes and calculations, including a large '2' and various numbers and symbols.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ISRAEL BIMBLICH					2a. DATE OF DEATH MONTH DAY YEAR March 5, 1985			2b. HOUR 6:15p.m.	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3543 Raymoor Road; 20895	
14 FATHER'S NAME FIRST MIDDLE LAST Shlomo Bimbllich				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Maryland 20895 Lillian Bimbllich; 3543 Raymoor Road; Kensington,					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary occluded infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>under 1 year</u> <u>15 years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>78</u> to <u>March 5</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>Feb 28</u> 19 <u>85</u> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
22b. SIGNATURE <u>Blaine H. Eig</u>		DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3-6-1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE H. EIG		22e. ADDRESS <u>9801 Maryland Drive, Bethesda 20902</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 7, 1985		23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Oxon Hill, Maryland			
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		24b. DATE REC'D. BY REGISTRAR 1 1985		24c. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

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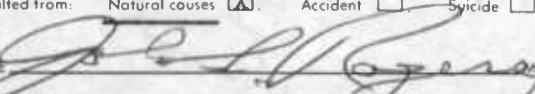



STREET MOTION & CO

WILKINSON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Dale R. Blackmer						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 3/13 19 85		7a. HOUR 8:00 A.							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jun. 1, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 3/13 19 85		7b. HOUR 8:00 A.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12809 Layhill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk				12b. KIND OF BUSINESS OR INDUSTRY GAO			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12809 Layhill Road				20906	
14. FATHER'S NAME FIRST MIDDLE LAST Glenn C. Blackmer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adaline Rapson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 383-09-2734				17. INFORMANT Ardeth Gies Niece				ADDRESS 1285 N. Byron Rd. Howell, Michigan			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None												APPROXIMATE TIME BETWEEN ONSET AND DEATH 48-64 HRS			
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy MEDICAL EXAMINER						DATE SIGNED 3/13/85					
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE MAR. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24. FUNERAL DIRECTOR NAME Francis J. Collins						25a. DATE REC'D. BY REGISTRAR MAR 18 1985				25b. REGISTRAR'S SIGNATURE 					
500 University Blvd., W. Silver Spring, Md.															

8:00
8:15
8:30

3:15
3:30

Bloomman

Leif

June 1, 1917

White

Montgomery County

12809 Layhill Road

Silver Spring

12809 Layhill Road

Silver Spring

Montgomery

Maryland

Acute myocardial disease.

None

None

None

X

X

22:35

1919 Seminary Road

Silver Spring, Montgomery, Md.

John S. Rogers, M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 / 7 6

088093

1. FOR
STATE
REGISTRAR

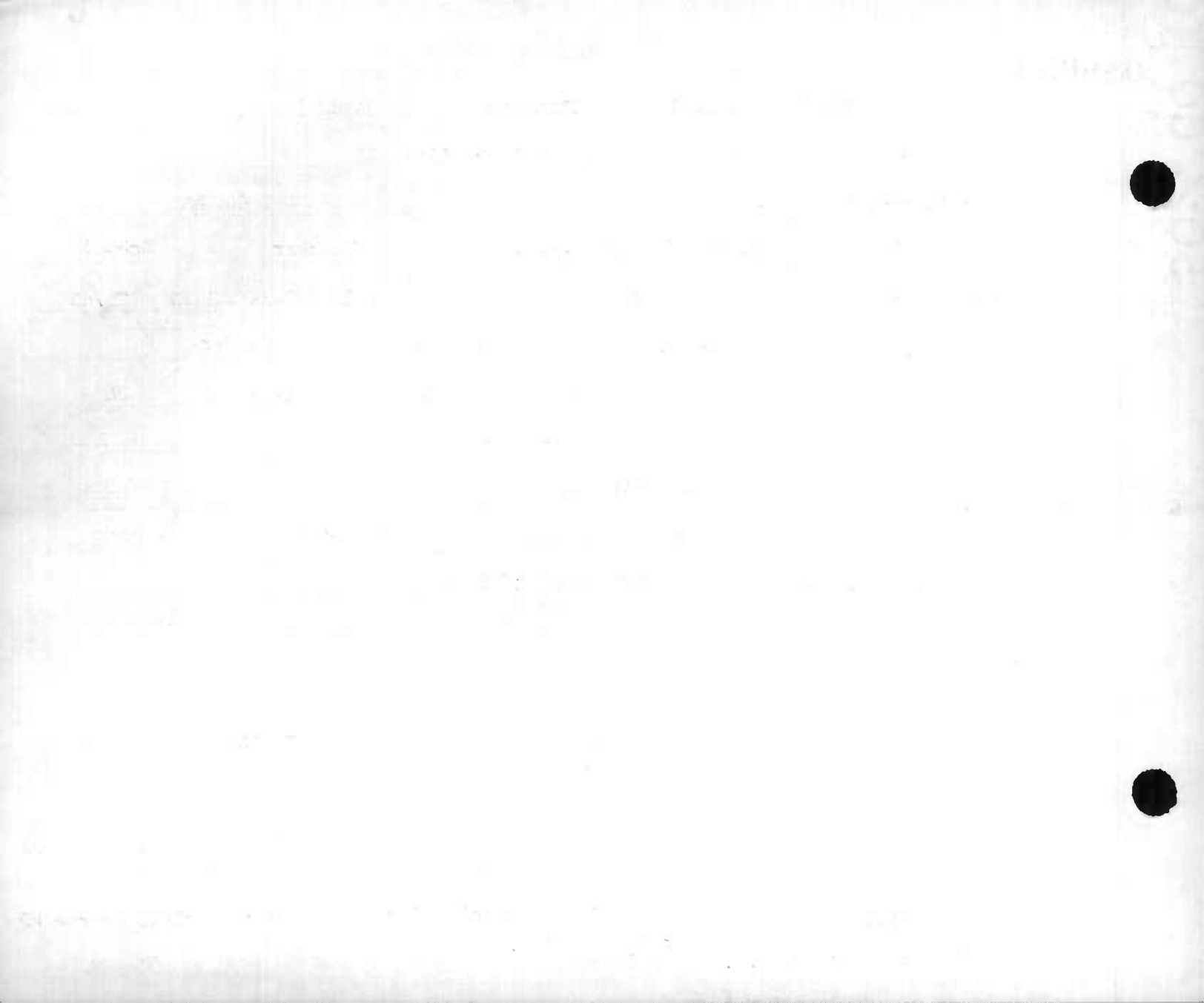
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY SAMUEL BLACKMON			2a. DATE OF DEATH MONTH DAY YEAR MARCH 14, 1985		2b. HOUR 8:25A M
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 2, 1956		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 28	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY SEAT PLEASANT	13c. CITY OR TOWN SEAT PLEASANT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7322 JOPLIN STREET 20743
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Blackmon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelmena Pender			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No none		16b. SOCIAL SECURITY NO. 577-78-7725		17. INFORMANT ADDRESS MR. SAMUEL BLACKMON (FATHER) SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMOCYSTIS PNEUMONIA					3 WEEKS
DUE TO, OR AS A CONSEQUENCE OF (c) ACQUIRED IMMUNE DEFICIENCY SYNDROME					1 year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ACID-FAST BACILLI GROWN FROM SPUTUM 2/25/85					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 7, 1985 to MARCH 14, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 14, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE Douglas L. Malby		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Mar 14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas L. Malby		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-19-85	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Prince George MD
24. FUNERAL DIRECTOR Marshall's Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Pendell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.



082130

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GRACE R. BLAIR			2a. DATE OF DEATH MONTH 3 DAY 3 YEAR 85			2b. HOUR 5 19 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH JULY 10 25		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland				13b. CITY OR TOWN Silver Spring		13c. STREET ADDRESS / ZIP CODE 11 Stanley Road 20904	
14. FATHER'S NAME FIRST George MIDDLE M. LAST Landis				15. MOTHER'S MAIDEN NAME FIRST Nora MIDDLE LAST Walsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Nevin Blair-husband- (same as 13c)			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

*Respiratory Failure
Cause of Breasts Lung involvement in*

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3 12 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/2/85 to 3/3/85 , that (I) (we) last saw the deceased alive on 3/2/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE MARGIN D. WATZ		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARGIN D WATZ		22e. ADDRESS 7525 Greenway Dr. Greenbelt MD					

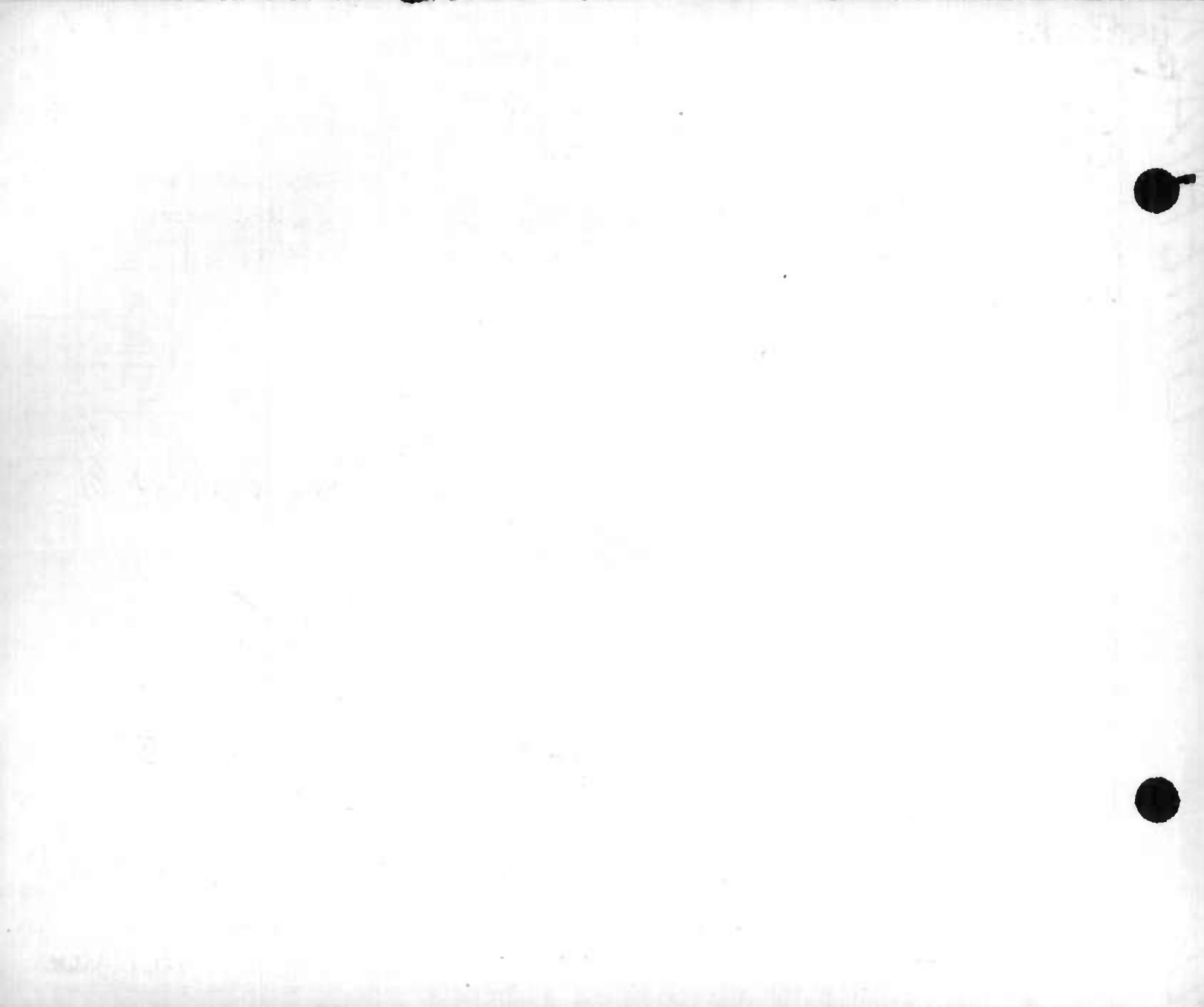
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Mar. 6, 1985		23c. NAME OF CEMETERY OR CREMATOR Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chambersburg Franklin Penna.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 11 1985	
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.



Cleared With Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

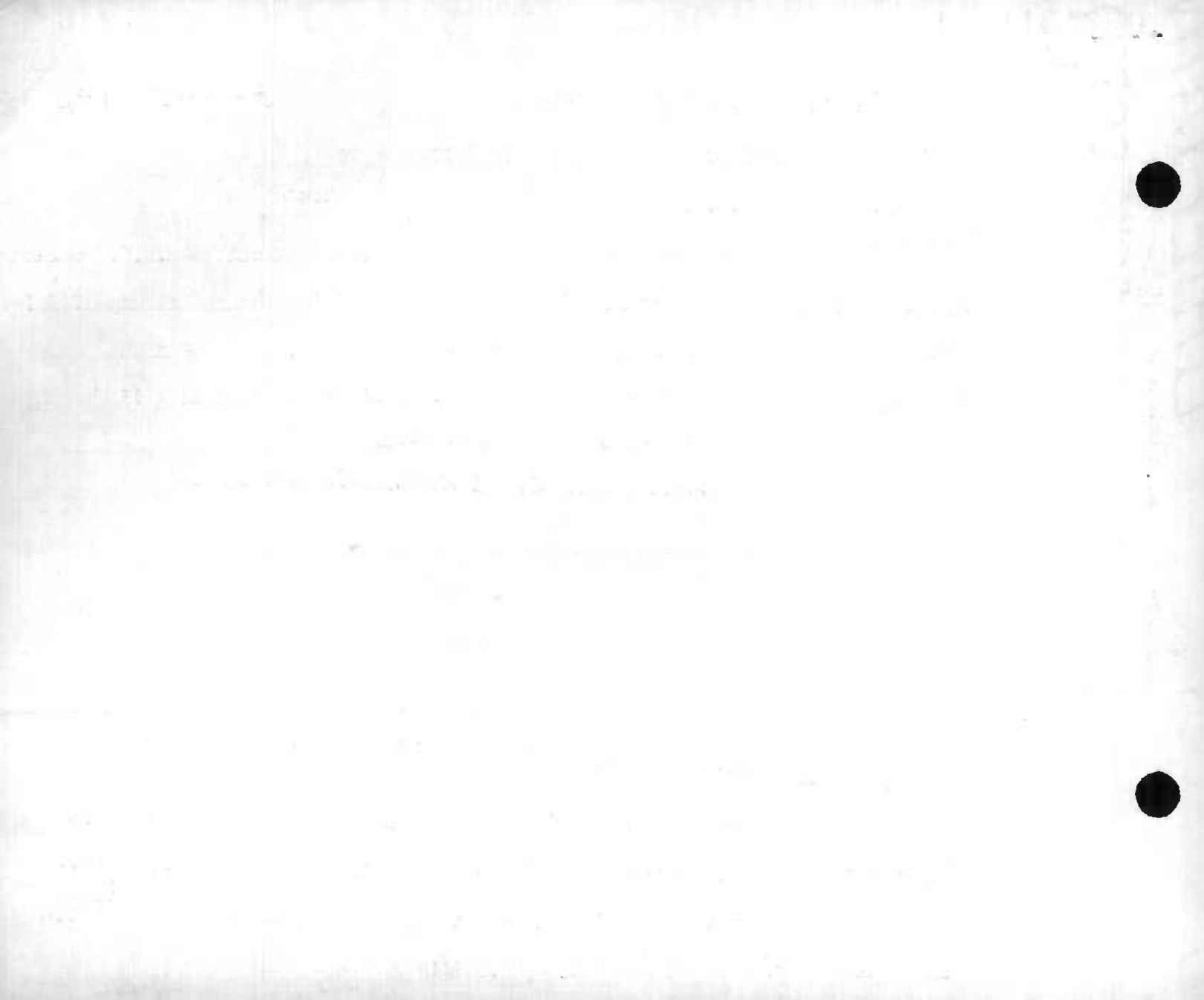
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) RALPH EDMUND BOWER			2a. DATE OF DEATH MONTH DAY YEAR 3-2-85		2b. HOUR 1²³ A. M.	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR MAY 16 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Neg. Engraver		12b. KIND OF BUSINESS OR INDUSTRY U.S.P. Commerce	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9305 Longbranch Parkway 20901	
14. FATHER'S NAME FIRST MIDDLE LAST Ralph Martindale Bower			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-05-3873		17. INFORMANT ADDRESS Marion B. Bower -Wife same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebral Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Mar 1 , 19 85 , to Mar 2 , 19 85 , that (I) (we) last saw the deceased alive on Mar 2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Bernard A. Fitzgerald M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-2-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING, MD		
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE 3-6-85		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria 20901 Virginia
24. FUNERAL DIRECTOR NAME ADDRESS Francis J. Collins 500 University Blvd. West Silver Spring, Md. 20901				25a. DATE REC'D. BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE [Signature]

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THEODORE HERMAN BOWMAN		2a. DATE OF DEATH MONTH DAY YEAR 3-26-85		2b. HOUR 8:30 AM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 27, 1899	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS	
10. CITY OR TOWN OF DEATH KENNISTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON GARDENS NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. STREET ADDRESS / ZIP CODE 10019 REDDICK DRIVE 20901	
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN BOWMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA WACK		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERINTENDANT OF PARKS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 101-32-2850		17. INFORMANT ADDRESS JANET B. WHEELER SAME AS 13 DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis (multiple)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Infarct arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20' 6 wks. 5 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>1) Deep Coma secondary to above</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>85</u> , to <u>3/26</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/22</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Stephen Jones</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/26/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN JONES		22e. ADDRESS ROCKVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/30/85		23c. NAME OF CEMETERY OR CREMATORY POUGHKEEPSIE RURAL CEM.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		23d. LOCATION CITY OR TOWN COUNTY STATE POUGHKEEPSIE DUTCHESS NY		23e. DATE REC'D. BY REGISTRAR APR 1 1985	
25. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," it must be filled in. If not, any injury, or other traumatic event, the medical examiner must be notified at once.

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NO 10



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 / 8 0

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) William H. Brennan			2a. DATE OF DEATH MONTH DAY YEAR MAR 28 1985		2b. HOUR 551P				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 21, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN) PENNSYLVANIA		8b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES BRENNAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH CORCORAN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11 577-38-5777		17. INFORMANT THOMAS BRENNAN		ADDRESS BROTHER SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE									
(c) PULMONARY FIBROSIS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 18, 1985 to March 28, 1985 , that (I) (we) last saw the deceased alive on March 28, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-28-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				22e. ADDRESS 277 University Blvd East, Silver Spring Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/1/85		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE RECEIVED BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			
25c. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

MEDICAL CERTIFICATION

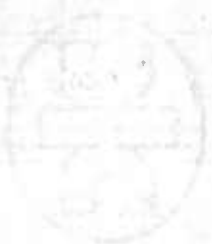
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "AT WORK" it shows pay injury, or other traumatic event, the medical examiner must be notified.

BP

001013



651018

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08 / 81

1. DECEASED NAME (TYPE OR PRINT) FLORENCE			2a. DATE KNOWN OF DEATH ESTIMATED March 15, 1985			2b. HOUR 7:00 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 10, '25	6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD March 15, 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Sil. Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12805 Bluet Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spg.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12805 Bluet Lane 20906		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Levine			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Strauss			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		
16a. SOCIAL SECURITY NO. 213-40-7441			17. INFORMANT Silver Spring, Md. 20906 Irving Braunstein; 12805 Bluet Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Carcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF (c) -----								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John P. Rogers</i>			TITLE (SPECIFY) <i>Dep.</i> M.D.			MEDICAL EXAMINER <i>March 16/85</i>		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 17, 1985		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels			ADDRESS 1170 Rockville Pike			25a. DATE REC'D. BY REGISTRAR MAR 19 1985		
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 27 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

NOV 10 1912

NOV 10 1912



NOV 10 1912

077137

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 / 8 2

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bertha L. Briggs			2a. DATE OF DEATH MONTH 3 DAY 11 YEAR 85			2b. HOUR 10:10 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 11 DAY 27 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARSHALL N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SILVER SPRING MANOR NURSING HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE (RET)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2700 BARKER 20901			
14. FATHER'S NAME FIRST GARRETT MIDDLE CRITTENDEN LAST BRIGGS						15. MOTHER'S MAIDEN NAME FIRST MATTIE MIDDLE FERGURSON LAST FERGURSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK				16b. SOCIAL SECURITY NO. 239-03-8677				17. INFORMANT ADDRESS ETHEL BRIGGS BISHOP 111 NEWLAND AVE ASHEVILLE, N.C. 28804			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **PNEUMONIA**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASPIRATION**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ARTERIOSCLEROTIC VASCULAR DISEASE**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**6 WEEKS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 27 DEC 1984 to 11 MAR 1985 , that (we) last saw the deceased alive on 7 MAR 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Walter E. Gooch MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOCH MD		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD					

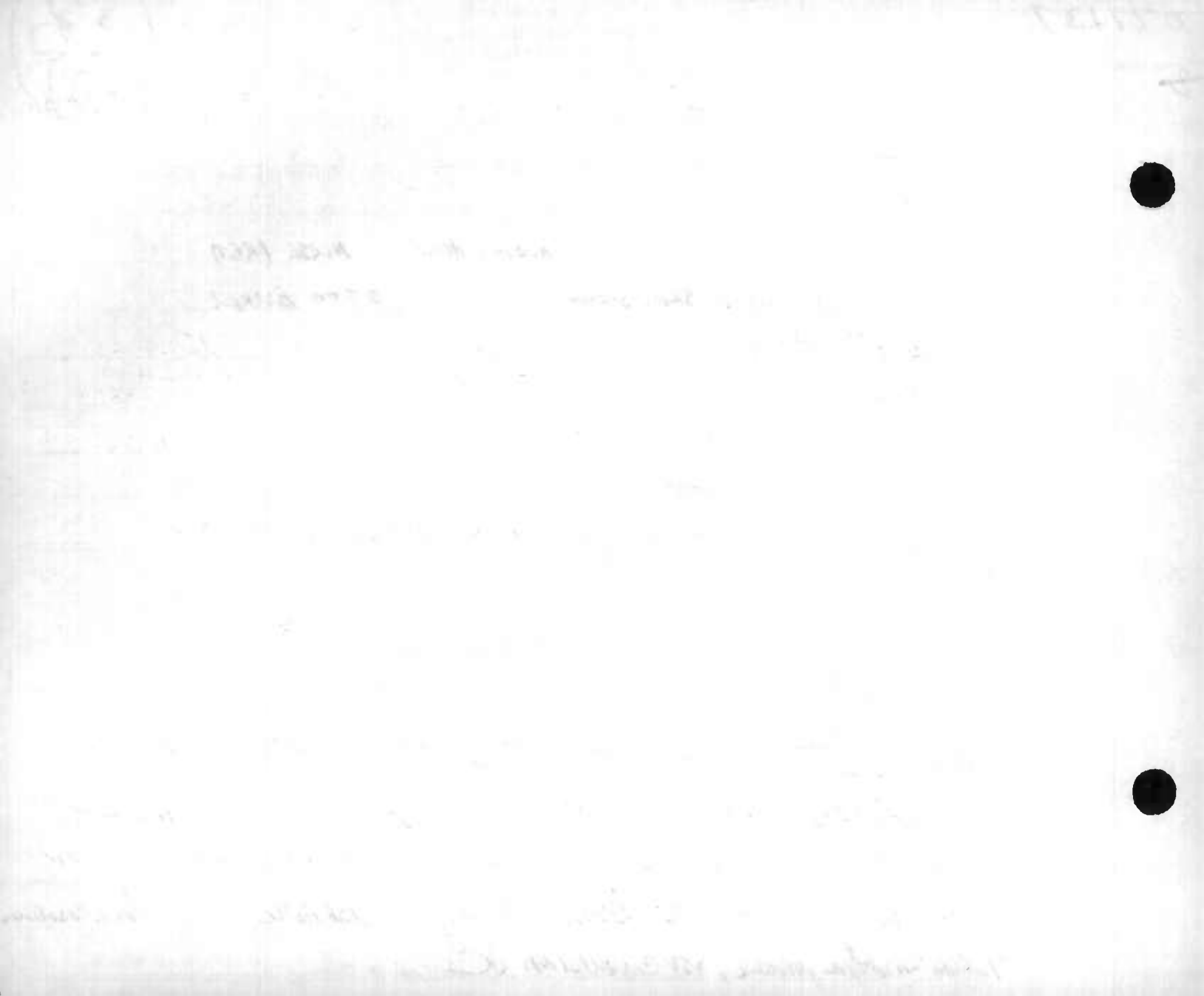
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 1985		23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		23d. LOCATION CITY OR TOWN Asheville COUNTY North Carolina	
24. FUNERAL DIRECTOR NAME TORREY FUND AMELIA J. GONNELL ADDRESS 255 CANNONVILLE DR				25a. DATE REC'D. BY REGISTRAR 4 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and of course.

BP



1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
TIFFANY NICOLE BROCKMANN						MARCH 4 1985				10:30 ^{am}			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
FEMALE		CAUCASIAN		MARCH 2 1985		YRS			2				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
MARYLAND		UNITED STATES				MONTGOMERY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL				N/A				N/A			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS?						13e. STREET ADDRESS / ZIP CODE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13904 CASTLE BOULEVARD 20904					
MARYLAND		MONTGOMERY		SILVER SPRING									

14. FATHER'S NAME FIRST MIDDLE LAST CHARLES ST. JOHN BROCKMANN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERESA COLENE ADKINS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	N/A	CHARLES S. BROCKMANN	13904 CASTLE BLVD. #102

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		SILVER SPRING, MD 20904		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>PREMATURITY</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>HYALINE MEMBRANE DISEASE</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:d

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY <table border="1"> <tr> <td>HOUR</td> <td>A.M.</td> <td>MONTH</td> <td>DAY</td> <td>YEAR</td> </tr> <tr> <td>P.M.</td> <td></td> <td></td> <td></td> <td>19</td> </tr> </table>	HOUR	A.M.	MONTH	DAY	YEAR	P.M.				19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
HOUR	A.M.	MONTH	DAY	YEAR								
P.M.				19								

MEDICAL HISTORY	21d INJURY OCCURRED	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION			
	WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		STREET	CITY OR TOWN	COUNTY	STATE

22a I certify that (I) (the decedent) attended the deceased from MARCH 2, 1985, to MARCH 4, 1985, that (I) last
saw the deceased alive on MARCH 4, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (edit) (and not) view the body after death.

21a. SIGNATURE <i>J. J. Hedin MD</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>5 March 1998</i>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
J. H. NADING, LCDR, MC, USN	NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814

73a. BURIAL, CREMATION, REMOVAL (SPECIFY)	73b. DATE	73c. NAME OF CEMETERY OR CREMATORY	73d. LOCATION CITY OR TOWN	COUNTY	STATE
Removal	5 Mar 85	Uniformed Services Univ. of the Health Sciences	Bethesda, Maryland		

74 FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA	75b DATE RECD. BY REGISTRAR MAR 8 1985	75c REGISTRAR'S SIGNATURE <i>De Davidson-Randall</i>
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TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked as fatal, all other causes of death, such as an injury, or other traumatic event, the medical examiner must be notified.

IMPORTANT: If item 2 is marked as "No," it is marked as "No" for all other items. The medical examiner may be notified if you are marked as "No" for any item.

MEDICAL CERTIFICATION

02-1-32

7

RECEIVED MOTION PICTURE

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

088020

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PR-1000, PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bertha H. Brown			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-22 1985			2b. HOUR 6:10 PM		
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10-8-00	6. AGE (IN YEARS) LAST BIRTHDAY 84 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-22 1985	2d. HOUR 6:10 PM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9727 Mt. Pisgah Rd. 20903			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Hill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathleen Simonds					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-46-8462		17. INFORMANT ADDRESS Arthur Brown, same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Improper antidiuretic hormone DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular Accident								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Fracture upper & lower rt. pubic ramus								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 9:35 P.M. 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Mt. Pisgah Rd. Silver Spring Montgomery MD				
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE John S. Rogers				TITLE (SPECIFY) M.D.		MEDICAL EXAMINER John S. Rogers		DATE SIGNED March 23/85
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road, Silver Spring, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/24/85		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi's Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall		
11800 New Hampshire Avenue, S.S., MD 20904								

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Main body of handwritten text, appearing to be a list or series of entries, though the characters are mostly illegible.

Bottom section of handwritten text, possibly a signature or footer, including the word "RECEIVED" and some illegible characters.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DONALD FRANCIS BROWN			2a. DATE OF DEATH MONTH DAY YEAR MAR 22 85			2b. HOUR 6:10p M				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 28 36		6. AGE (IN YEARS (LAST BIRTHDAY)) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MI		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY NAVY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA					13b. CITY OR TOWN PRINCE WILLIAM WOODBRIDGE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13015 KETTERMAN DRIVE 99999	
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL FRANCIS BROWN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DOROTHY BROWN Ciewski					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 55-74		17. INFORMANT ADDRESS FRANCES MARLENE BROWN						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC ENCEPHALOPATHY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) METASTATIC COLONIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 18 MARCH 19 85 , to 22 MARCH 19 85 , that (I) (we) last saw the deceased alive on 22 MARCH 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE LT Robert P. Thiel MC, USN					DEGREE MO ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 23 March 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT P. THIEL LT, MC, USN					22e. ADDRESS NAVAL HOSPITAL BETHESDA					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 25, 1985		23c. NAME OF CEMETERY OR CREMATORY Stafford Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Stafford, Virginia		
24. FUNERAL DIRECTOR Woodbury Co. Caecilia + Hornell					25a. DATE REC'D. BY REGISTRAR MAR 27 1985			25b. REGISTRAR'S SIGNATURE Davidson-Randall		

2878

010020

REBEL MOTION PICTURE

CHILDREN



093148

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret F. Bruce			2a. DATE OF DEATH MONTH 3 DAY 29 YEAR 85			2b. HOUR 10:45^{PM}						
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH 12 DAY 22 YEAR 1900		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.						
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16513 Hampton Drive, 20877				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 16513 Hampton Drive, 20877		
14 FATHER'S NAME FIRST John MIDDLE LAST Grosscup				15 MOTHER'S MAIDEN NAME FIRST Ella MIDDLE LAST Cook								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-22-5315		17 INFORMANT ADDRESS William L. Bruce, Jr. same as #13e						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Histiocytic Lymphoma.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Feb 1985		
DUE TO, OR AS A CONSEQUENCE OF (b) 												
DUE TO, OR AS A CONSEQUENCE OF (c) 												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Mal nutrition												
19a. DATE OF OPERATION 2/13/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Kidney mass				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from January 19 85 to March 29 19 85 , that (I) (we) last saw the deceased alive on March 29 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Susan J. Withrow						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/30/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan J. Withrow						22e. ADDRESS 15 E. Deer Park Dr, Gaithersburg Md. 20877						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-2-85		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Maryland				
24. FUNERAL DIRECTOR NAME Ruck Towson, Inc. ADDRESS 1050 York Road Towson, Maryland 21204						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 11 - 1985						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8150

detonant:

Figure 3

077006

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 / 8 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Saidee C. Bryne			2a. DATE OF DEATH MONTH DAY YEAR March 6, 1985		2b. HOUR 10:07A M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 10 1911		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 74 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maine		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technical Writer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 18437 Lost Knife Circle 20879			
14. FATHER'S NAME FIRST MIDDLE LAST Oscar B. Parter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Robinson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 579-07-9050		17. INFORMANT Gaithersburg, Maryland 20879 Patrick Bryne 8505 Hawkins Creamery Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic obstructive pulmonary disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>2/27/85</u> , 19 <u>85</u> , to <u>3/6/85</u> , 19 <u>85</u> , that (1) (two) lost saw the deceased alive on <u>3/6/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.											
22b. SIGNATURE <u>Pasqual Perrino</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/6/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pasqual Perrino, M.D.			22e. ADDRESS 15 East Deerpark Drive, Gaithersburg, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 3-7-85		23c. NAME OF CEMETERY OR CREMATORY Georgetown U. Med. School			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC			
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services Washington, D.C. 20011											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Technical Officer, U.S. Government

Chief, U.S. Customs Service

Director, U.S. Customs Service

U.S. Customs Service, New York

2007

U.S. Customs Service, New York

U.S. Customs Service, New York

U.S. Customs Service, New York

088105

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 / 8 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) JAMES WILLIAM BYRD			2a DATE OF DEATH MONTH DAY YEAR MARCH 15 1985		2b HOUR 8:00 P
3 SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 26 1931		6 AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b CITIZEN OF WHAT COUNTRY? UNITED STATES	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVALHOSPITAL		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE VIRGINIA			13b COUNTY FAIRFAX	13c CITY OR TOWN ALEXANDRIA	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST EDWARD BYRD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA GRAF		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1950-1980		17. INFORMANT ADDRESS SUMIKO H. BYRD, 3114 SPRING DRIVE, ALEXANDRIA, VA 22306	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANGIOEDEMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from MARCH 8 , 19 85 , to MARCH 15 , 19 85 , that (I) (we) lost saw the deceased alive on MARCH 15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE E S Killeavy		DEGREE MD		22c. DATE SIGNED 18 Mar 85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) E. KILLEAVY, LT, MC, USN		22e ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD 20814			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/20/85	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA	
24 FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 22 1985 Julia Davidson		

01220

087009

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Flora J. Byrne			2a. DATE OF DEATH MONTH DAY YEAR March 15 1985			2b. HOUR 8 A		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 22, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Jacobs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Eleanor Norville				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-09-7532		17. INFORMANT Thornhill, ADDRESS Ontario, Canada Mrs. Florence Gurr 73 Royal Orchard Blvd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Organic brain syndrome Fractured hip (2 years ago)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1 , 19 81 , to March 15 , 19 85 , that (I) (we) lost saw the deceased alive on March 4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Morton A. Kavalier</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-15-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton A. Kavalier, M.D.				22e. ADDRESS 1145 --19th St N.W. Wash., D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-18-1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. 5130 Wisconsin Ave., N.W. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR MAR 21 1985				

02/05/20

(one copy) and forward to appropriate officials

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 7 9 0

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herbert M. Burdette			2a. DATE OF DEATH MONTH DAY YEAR March, 11, 1985			2b. HOUR 11:59am	
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05- 12- 1914		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	
12b. KIND OF BUSINESS OR INDUSTRY Dairy		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13d. STREET ADDRESS 22204 Slidell Rd. 20841		14. FATHER'S NAME FIRST MIDDLE LAST Herbert K. Burdette		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie M. Piquette			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-6399		17. INFORMANT ADDRESS Jerri Lynn Oglesby, Item 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

9 min.

DUE TO, OR AS A CONSEQUENCE OF

(b) Respiratory arrest

10 min.

DUE TO, OR AS A CONSEQUENCE OF

(c) Hypotension

8 hours

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Septicemia and Left Lung Infiltrates

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22a. SIGNATURE (Type or Print) Jules Lodish, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jules Lodish, M.D.				22e. ADDRESS 2901 Olney Sandy Spring Rd., Olney, Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Bethesda Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Browningsville, Montg., Md.	
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24. FUNERAL DIRECTOR Orin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR MAR 18 1985				25b. REGISTRAR'S SIGNATURE Julia Burdette-Rodell			
---	--	--	--	--	--	--	--	---	--	--	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 how many injury, or other traumatic event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

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Figure 1

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as such, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Florence Watson Burdick						2a. DATE OF DEATH MONTH DAY YEAR 3-6-85			2b. HOUR 5:50 a.m.		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV. 6, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PIANO-INSTRUCTOR		12b. KIND OF BUSINESS OR INDUSTRY MUSIC			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2108 DEXTER AVENUE # 102 20902			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN S. WATSON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JEANNE DUNLOP							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-28-9040		17. INFORMANT 2106 Dexter Avenue # 103 Silver Spr., Maryland 20902 JEAN B. EAMMELLI - DAUGHTER							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarction										5 days	
(c) Coronary thrombosis										5 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) chronic obstructive pulmonary disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Mar 5, 1985 to Mar 6, 1985 , that (I) (we) last saw the deceased alive on Mar 5, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Seruch T. Kimble				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-6-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SERUCH T. KIMBLE, M.D.				22e. ADDRESS 9801 Georgia Ave, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3-9-85		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D.C.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.						25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall			

BP

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George E		FIRST George		MIDDLE E		LAST Burford		2a. DATE OF DEATH MONTH May		DAY 9		YEAR 85		2b. HOUR 7:58		AM AM			
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH 04		DAY 10		YEAR 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83		YRS.		7. IF UNDER 1 YEAR MONTHS 		DAYS 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery													
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE, GIVE FULL ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Doctor		12b. KIND OF BUSINESS OR INDUSTRY Medical													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE New York		13b. COUNTY Tompkins		13c. CITY OR TOWN Ithaca		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 482 Kruma Corners 14850											
14. FATHER'S NAME FIRST George		MIDDLE Edgar		LAST Burford		15. MOTHER'S MAIDEN NAME FIRST Alice		MIDDLE 		LAST McCann									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 129-34-4888		17. INFORMANT Judith B. Doran ADDRESS Springfield, Va.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (b) Probable New M.I. DUE TO, OR AS A CONSEQUENCE OF: (c) 														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (the hospital) attended the deceased from 2/11 , 19 85 , to 3/19 , 19 85 , that (I) (we) lost saw the deceased alive on 3/6 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.																			
22b. SIGNATURE Card Bender for J.B. Fitzgerald														DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/11/85		23c. NAME OF CEMETERY OR CREMATORY VALLEY VIEW CEMETERY				23d. LOCATION (CITY OR TOWN COUNTY STATE) TICONDEROGA, NEW YORK											
24. FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC ALEXANDRIA, VIRGINIA								ADDRESS 		25a. DATE REC'D. BY REGISTRAR MAR 20 1985								25b. REGISTRAR'S SIGNATURE Julia Davidson-Rodgers	

DIVISION OF VITAL RECORDS 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

10-10-68 10:00 AM

0740-39
OKSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8508793

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James E Burroughs			2a. DATE OF DEATH MONTH 3 DAY 10 YEAR 85		2b. HOUR 6:17 P.M.	
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH 7 DAY 4 YEAR 11		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS 	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber	12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 404 S. Williamsburg Dr. 20901				
14. FATHER'S NAME FIRST JAMES MIDDLE E. LAST BURROUGHS		15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE ELIZABETH LAST SCHREYER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW 11		16b. SOCIAL SECURITY NO. 578-03-7722		17. INFORMANT 3502 Sugar Maple Court Waldorf, Md. 20601 DIANE L. WINTER - DAUGHTER		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LIVER DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHIAL CARCINOMA Lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) 						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 5, 1985 , to March 10, 1985 , that (I) (we) lost saw the deceased alive on MARCH 10, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Bernard A. Fitzgerald MD		DEGREE		22c. DATE SIGNED 3-10-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD		22e. ADDRESS 217 UNIVERSITY BLVD EST, SILVER SPRING, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN SUITLAND COUNTY 20901 STATE PR. GEO. MARYLAND		23e. DATE REC'D BY REGISTRAR MAR 13 1985 23f. REGISTRAR'S SIGNATURE [Signature]				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

7

James E. Smith

March 17, 1881

Dear Mr. [illegible]

I have just received your letter of the 15th

and am glad to hear from you.



I am sure you will find the enclosed of interest.

I am, Sir, very respectfully,

Your obedient servant,

James E. Smith

Prophet and President of the Church of Jesus Christ of Latter-day Saints

Salt Lake City, Utah

Enclosed are the [illegible]

and [illegible]

I am, Sir, very respectfully,

Your obedient servant,

James E. Smith

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George L. Burrows			2a. DATE OF DEATH MONTH DAY YEAR 03 04 85			2b. HOUR 12:30AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Machinist		12b. KIND OF BUSINESS OR INDUSTRY Newspaper		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15313 Carrollton Rd. /20853	
14. FATHER'S NAME FIRST MIDDLE LAST George Burrows					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Jenkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Joyce B. Praschil, see #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Hypoxia		days
DUE TO, OR AS A CONSEQUENCE OF (c) Massive Pulmonary Embolism		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
Malignant Lymphoma

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/3 , 19 85 , to 3/4 , 19 85 , that (I) (we) last saw the deceased alive on 3/4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jules R. Lodish				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULES R. LODISH				22e. ADDRESS 2901 OLNEY-SANDY SPRING ROAD, OLNEY, MD			

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Mar. 6, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 8 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.



0870411

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8795

1 DECEASED NAME (TYPE OR PRINT) Charles Callahan			2a DATE OF DEATH MONTH 3 DAY 17 YEAR 85		2b. HOUR M
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH 10 DAY 10 YEAR 22		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Washington Adventist Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Heat & Air Condit.
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland Montgomery Wheaton			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST Charles MIDDLE Patrick LAST Callahan			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Virginia LAST Mulvaney		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Son-Richard Callahan	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (c) Brain metastases					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/25 19 85 to 3/17 19 85 that (we) lost saw the deceased alive on 3/15 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) did not view the body after death.					
22b SIGNATURE Peter B. Sherer		DEGREE MD		22c DATE SIGNED 3/18/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD		22e ADDRESS 3947 Ferrara St. Wheaton, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE March 21, 85		23c NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
23d LOCATION CITY OR TOWN Clarksburg		COUNTY West Va.			
24 FUNERAL DIRECTOR NAME Davis Funeral Home POB2806 Clarksburg, W.Va.			25a DATE REC'D. BY REGISTRAR IVIM 62 1985		25b REGISTRAR'S SIGNATURE <i>[Signature]</i>

140720



082135

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JULIA ANN CARLINER			2a. DATE OF DEATH MONTH DAY YEAR MARCH 4 1985		2b. HOUR 12 noon						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 6 04 08		6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS 12		IF UNDER 24 HRS. HOURS MIN. 34	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MD		13b. CITY OR TOWN WASHINGTON, D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4201 MASS. AVE. #1030C N.W. 20016					
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK J. REDDINGTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELIA BOURKE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-05-3148		17. INFORMANT THOMAS J. CARLINER - SON WASHINGTON, D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 4 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) CHRONIC LUNG DISEASE, MYXEDEMA											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/30 19 85 to 3/4 19 85 that (I) (we) last saw the deceased alive on 2/20 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ira Tublin M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/4/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRA TUBLIN M.D.				22e. ADDRESS 8830 Cameron Street Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-9-85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE OF DEATH MAR 11 1985				25b. REGISTRAR John R. Randle			
500 UNIVERSITY BLVD. WEST SILVER SPRING, Md.											



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Handwritten text below the top line, possibly a date or location.

Handwritten text below the second line, possibly a name or subject.

Handwritten text below the third line, possibly a description or details.

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Handwritten text below the fifth line, possibly a date or location.

Handwritten text below the sixth line, possibly a name or subject.

Handwritten text below the seventh line, possibly a description or details.

Handwritten text below the eighth line, possibly a signature or initials.

Handwritten text below the ninth line, possibly a date or location.

Handwritten text below the tenth line, possibly a name or subject.

Handwritten text below the eleventh line, possibly a description or details.

Handwritten text below the twelfth line, possibly a signature or initials.

Handwritten text below the thirteenth line, possibly a date or location.

Handwritten text below the fourteenth line, possibly a name or subject.

Handwritten text below the fifteenth line, possibly a description or details.

Handwritten text below the sixteenth line, possibly a signature or initials.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nadia A. Carlson		2a. DATE OF DEATH MONTH DAY YEAR 03 19 85		2b. HOUR 7:00 AM	
3 SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 5 20 13		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago IL		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Popruck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary UNK		16. STREET ADDRESS / ZIP CODE 1618 Maydale Drive 20904			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 028 05 1991		17. INFORMANT Ellen Carlson (Daughter) Same as 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>anoxia pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>stroke</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Ischemic heart disease, heart failure, diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>82</u> , to <u>Present</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/18</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK K LI		22e. ADDRESS 1721 University Blvd W, Wheaton					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/85		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION Keene, New Hampshire	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md				25. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE a Davidson-Randall	

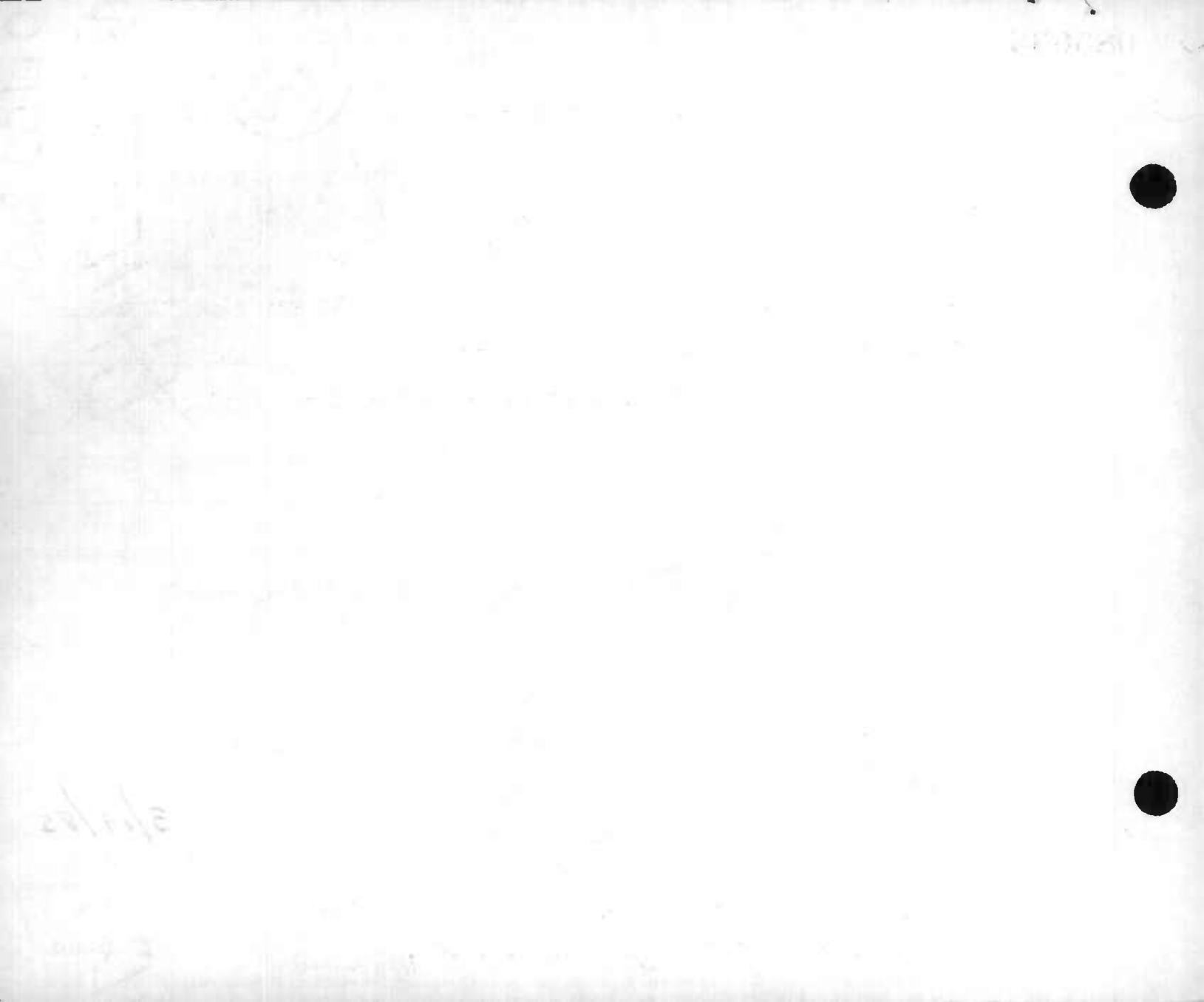
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 50M 4/B2
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) NELLIE Virginia CARR					2a. DATE OF DEATH MONTH DAY YEAR MAR. 21, 85				
3. SEX Female					2b. HOUR 8³⁰ P.M.				
4. RACE Caucasian					5. DATE OF BIRTH MONTH DAY YEAR November 26, 1890				
6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS					7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
7b. CITIZEN OF WHAT COUNTRY? U.S.A.					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Wheaton					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nursing Home				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. TREASURY DEPT					12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.				
13a. STATE Maryland					13b. COUNTY Montgomery				
13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Clarence					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gates				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 578-84-3446				
17. INFORMANT Naomi M. Farrabee					ADDRESS 3087 Brinkley Road Temple Hills, Md. 20748				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiac archy flunias DUE TO, OR AS A CONSEQUENCE OF (c) severe diabetic brain syndrome PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 81 , to 3/21 , 19 85 , that (I) (we) lost saw the deceased alive on 3/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph M. Solinas					DEGREE M.D.				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Solinas, M.D.					22d. ADDRESS 9801 Georgia Avenue Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 25, 1985			23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			24. FUNERAL DIRECTOR NAME Francis J. Collins						
25a. DATE REC'D. BY REGISTRAR MAR 26 1985			25b. REGISTRAR'S SIGNATURE Wendy W. Gordon						

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BY: J. G. [illegible]
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10.0 notations

2019.1.1

200 University Ave., 2nd Floor, New York, N.Y.

088089

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Allen Carter, Sr.			2a. DATE OF DEATH MONTH DAY YEAR March 18, 1985		2b. HOUR 8:40 PM
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Mar. 1, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Montg.	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry Carter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-20-1367		17. INFORMANT Mary Lee (Daughter)	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Obstructive Pulmonary Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from March 16, 1985 to March 18, 1985 , that (1) we lost saw the deceased alive on March 18, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we (1) did (1) did not view the body after death.					
22b. SIGNATURE Lewis Kellert, MD		DEGREE MD		22c. DATE SIGNED 3/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD		22e. ADDRESS 4000 Olney Laytonville Rd, Olney, Md. 20872			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-23-85	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850			

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

088083



DEPT. OF JUSTICE

RECEIVED

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

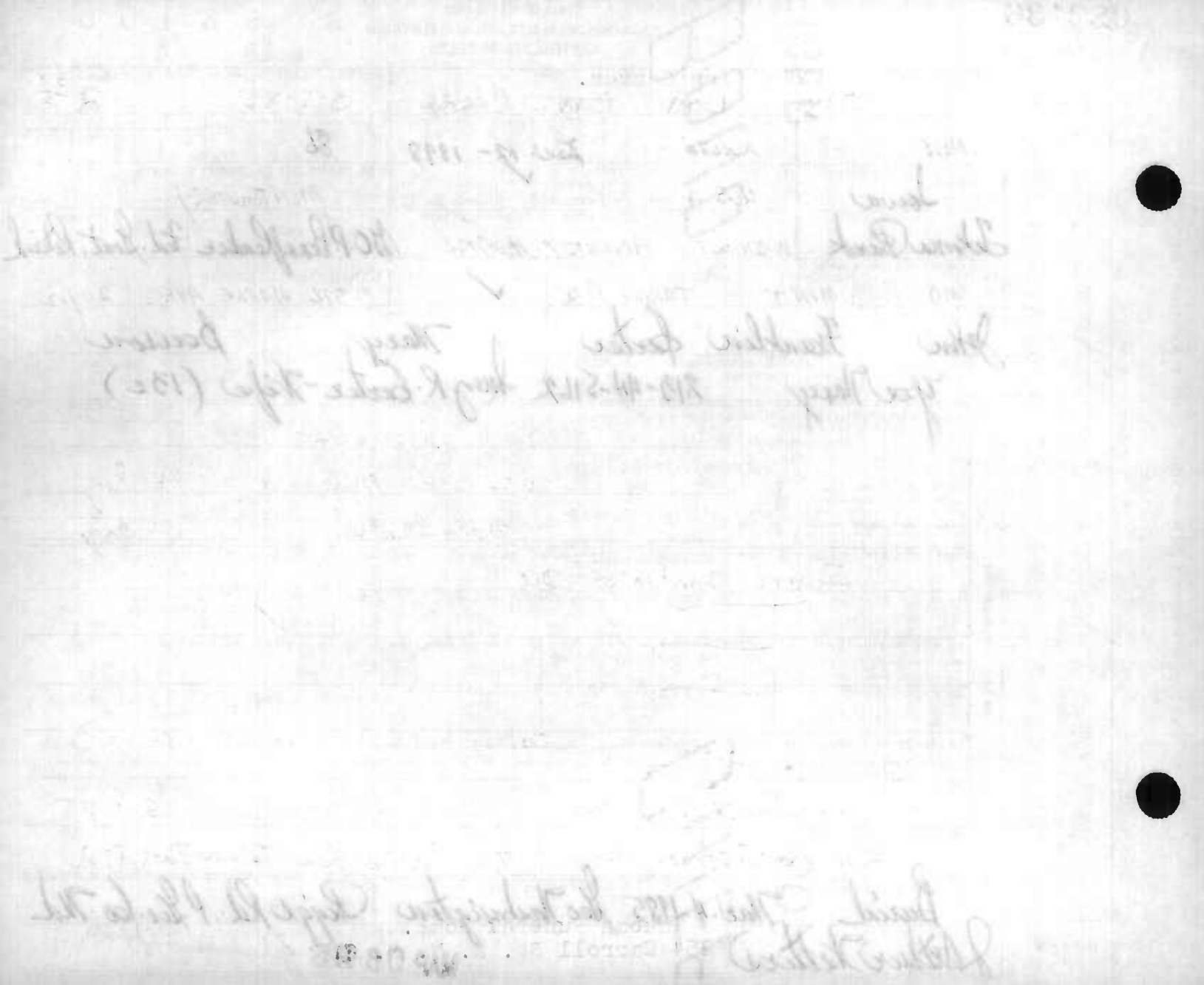
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Linn Carter.		2a. DATE OF DEATH MONTH DAY YEAR 3-1-85		2b. HOUR 2:30 AM	
1. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Dec. 12 - 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. UNDER 1 YEAR MONTHS DAYS 10. UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
13a. USUAL RESIDENCE (IF HAUSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Franklin Carter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Benson			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, FIRST UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Mary		16b. SOCIAL SECURITY NO. 213-44-5162		17. INFORMANT ADDRESS Mary R. Carter - Wife (13c)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral aneurysm DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aspirated pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) dehydration					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SEVERAL PARKINSON'S DR					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 81 to FEB 28 85 , that (I) (we) last saw the deceased alive on 2-28-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.H. Sandstrom		DEGREE MD		22c. DATE SIGNED 3-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.H. Sandstrom MD		22e. ADDRESS 7701 Carroll Ave Takoma Park, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 4 - 1985		23c. NAME OF CEMETERY OR CREMATORY Rockledge	
24. FUNERAL DIRECTOR John V. Vetter		25. ADDRESS 254 Carroll St. N.		26. DATE RECD. BY REGISTRAR Mar 06 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



087030

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Angel Castro		2a. DATE OF DEATH MONTH DAY YEAR 03-18-85		2b. HOUR 9:35 P.M.
3 SEX male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10-02-02		6. AGE (IN YEARS LAST BIRTHDAY) 82
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PONCE PUERTO RICO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CAB DRIVER	12b. KIND OF BUSINESS OR INDUSTRY TAXI
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. MONTGOMERY SILVER SPRING		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST DOMINGO CASTRO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA PLATA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 110-09-2711A		17. INFORMANT DOLORES CASTRO (SAME AS #13)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Aspiration Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Sepsis**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Parkinson's Disease**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 3/17 , 19 85 , to 3/18 , 19 85 , that (2) (we) last saw the deceased alive on 3/17 , 19 85 , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)			
22b. SIGNATURE Jay Weiner MD	DEGREE	22c. DATE SIGNED 3/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner MD	22e. ADDRESS 4701 F. J. Rd Rockville, Md		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 3-19-1985	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREM.	23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PGC Md.
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. INC. SILVER SPRING, MD		25a. DATE REC'D. BY REGISTRAR MAR 22 1985	25b. REGISTRAR'S SIGNATURE Carleton Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

021030



13311 NOTION 2/02

W.D. MINTA H. J.

2011

10/10/11

086096

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 0 2

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Eugene W Chamberlin			2a DATE OF DEATH MONTH DAY YEAR 03 21 85			2b HOUR 2:15AM				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 28, 1909		6 AGE (IN YEARS (LAST BIRTHDAY)) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OR WORK, BUSINESS, OR INDUSTRY) Engineer		12b KIND OF BUSINESS OR INDUSTRY Engineering		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland					13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Fredrick W. Chamberlin					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Van Wye					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) No			16b SOCIAL SECURITY NO. 142-20-0973		17 INFORMANT ADDRESS Edward C. Chamberlin 9205 Allenswood Rd. Randallstown, MD					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Histiocytic Lymphoma, liver, lymph nodes, lungs DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Colon cancer, cirrhosis, esophageal varices, gastritis, portal hypertension, renal failure**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) <u>the hospital</u> attended the deceased from <u>May</u> , 19 <u>84</u> , to <u>21 Mar</u> , 19 <u>85</u> , that (I) <u>was</u> last saw the deceased alive on <u>20 Mar</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>would</u> (did not) view the body after death.							
22b SIGNATURE Donald E. Dillon M.D.				DEGREE MD		22c DATE SIGNED 21 Mar 85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e ADDRESS 2901 Olney-Sandy Spring Rd. Olney, MD 20832			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE March 23, 1985		23c NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24 FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE Mar 26 1985	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

020420

UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D. C. 20315

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]



[The body of the memorandum contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal report or memorandum.]

100-100000

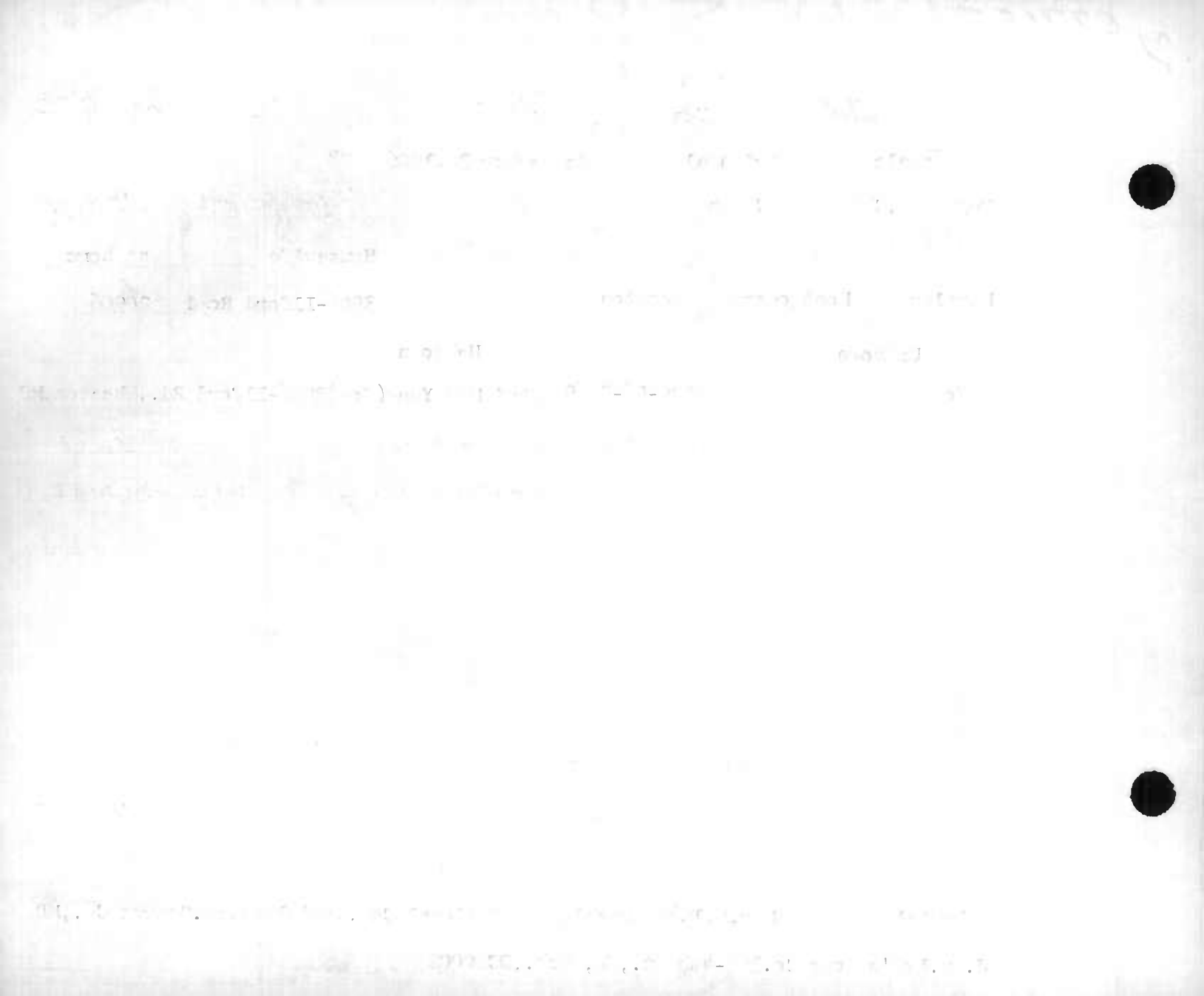
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MEI Yee CHAN				2a. DATE OF DEATH MONTH 3 DAY 6 YEAR 85 2b. HOUR 7:15 PM			
3. SEX Female		4. RACE Yee		5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 1906		6. AGE (IN YEARS (LAST BIRTHDAY)) 78 YES <input type="checkbox"/> NO <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Toy Shan, China		7b. CITIZEN OF WHAT COUNTRY? China		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Wheaton, Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Sen. Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Unknown MIDDLE Unknown LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST Unknown MIDDLE Unknown LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-96-3069		17. INFORMANT ADDRESS Shui Man Yung (Son) 3906-Ilford Rd., Wheaton, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tuberculosis & decub DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) months							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH 19 DAY 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/11 19 84 to 9/6/85 19 85 , that (I) (we) last saw the deceased alive on 1/24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Elba J. Martinez, M.D. DEGREE M.D.				22c. DATE SIGNED 2/6/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ELBA J. MARTINEZ, M.D.	
22e. ADDRESS 8808 HIDDEN HILLS LA - POTOMAC				22f. ADDRESS 8808 HIDDEN HILLS LA - POTOMAC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Washington National Cem., Suitland, Pr. George Co., MD		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002 ADDRESS Wash., DC 20002				25a. DATE REC'D. BY REGISTRAR MAR 13 1985			



18 085075

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth S. Chapman			2a. DATE OF DEATH MONTH DAY YEAR March 12 1985			2b. HOUR 6:40 A M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11- 23- 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Kentucky		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN Washington, D.C.		13d. STREET ADDRESS / ZIP CODE 3235 Patterson St., N.W. 20015			
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Simmons				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Morton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215- 54-9567		17. INFORMANT ADDRESS James R. Michal 1120 20th St. N.W. Wash.D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Right Middle</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 YEARS</u> <u>10 YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE				
22. I certify that (1) this hospital attended the deceased from <u>MARCH 82</u> , 19 <u>82</u> , to <u>MAR 12</u> , 19 <u>85</u> , that (2) (we) last saw the deceased alive on <u>FEB. 9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.									
22b. SIGNATURE <u>Philip R. James</u>						DEGREE <u>M.D.</u>		22c. DATE SIGNED 3/12/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip R. James, M. D.						22e. ADDRESS 5401 Western Ave. N. W. Washington, D. C. 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3- 15-1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. ADDRESS 5130 Wisconsin Avenue N.W. Washington, D.C.						25. DATE REC'D. BY REGISTRAR MAR 20 1985 <u>John Davidson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, signed by the funeral director, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

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Table 1. Continued

Introduction

Environ

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

092038

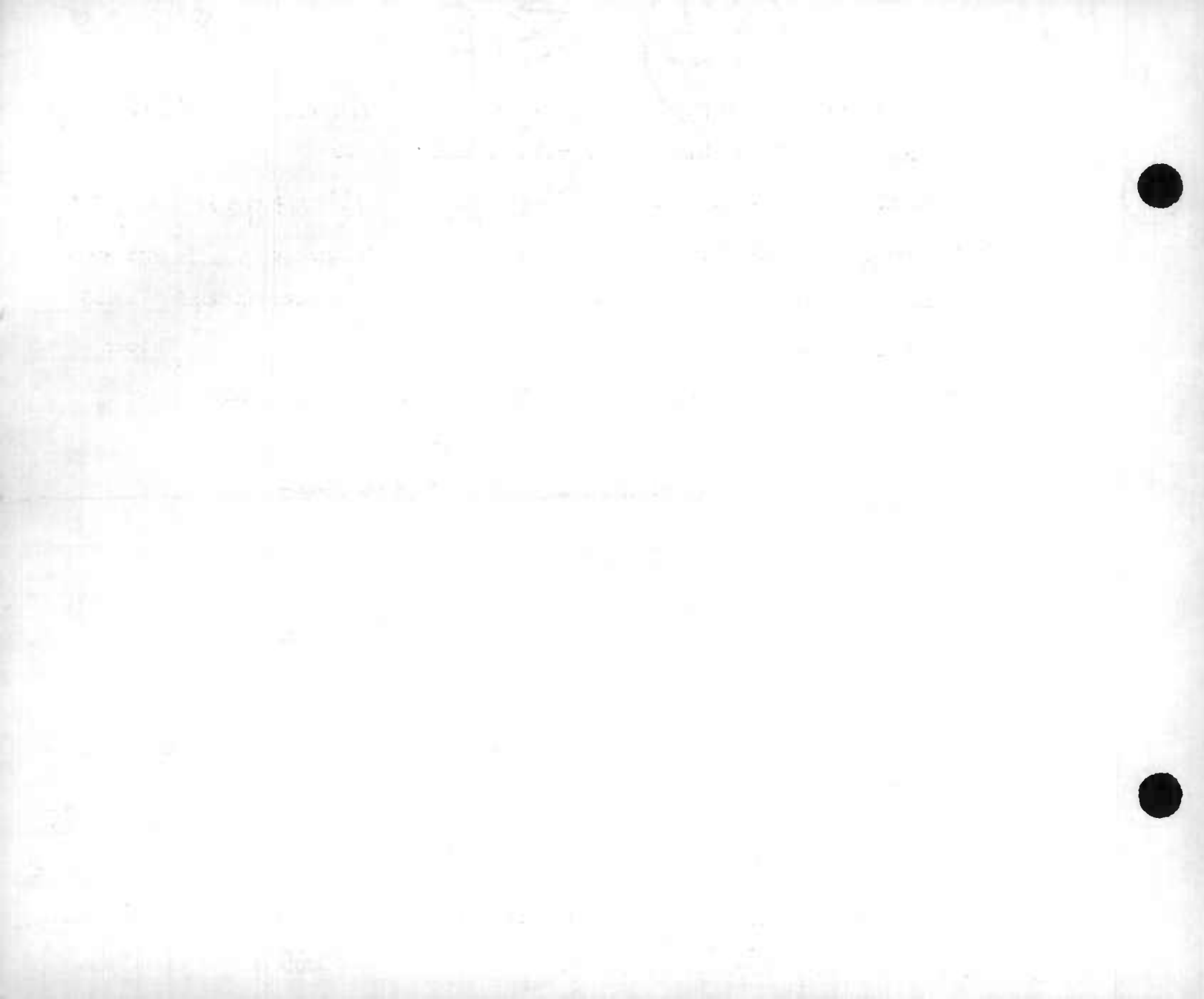
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gladys Pearman Chase			2a. DATE OF DEATH MONTH DAY YEAR Mar. 24, 1985		2b. HOUR 3 A.M.					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 13, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4212 Norbeck Road 20853	
14. FATHER'S NAME FIRST MIDDLE LAST William Newton Pearman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Shaver							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 115 42 6291		17. INFORMANT James A. Chase				ADDRESS same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cardiovascular thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1</u> , 19 <u>85</u> , to <u>3-24</u> , 19 <u>85</u> , that <u>all</u> (we) lost saw the deceased alive on <u>3-24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (there) (did) (did not) view the body after death.										
22b. SIGNATURE Donald R. Bucy			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-24-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.R. Bucy			22e. ADDRESS 809 Veirs Mill Rd. Rockville							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE March 27, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland 20850					25a. DATE REC'D. BY REGISTRAR MAR 28 1985					25b. REGISTRAR'S SIGNATURE John Davidson-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		Kun Hai Chin		8 5 0 8 8 0 6	
1 DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH	
FIRST MIDDLE LAST Kun H. Chin				MONTH DAY YEAR 3 9 '85	
3 SEX		4 RACE		5 DATE OF BIRTH	
Female		Chinese		MONTH DAY YEAR 11 03 1901	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		6 AGE (IN YEARS LAST BIRTHDAY)	
Canton, China		United States		YRS. MONTHS DAYS 3 9 15	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH	
Takoma Park		Washington Adventist Hospital		Montgomery MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		13a STREET ADDRESS / ZIP CODE	
Housewife		at home		8328-Navahoe Drive 20903	
13a STATE		13b COUNTY		13c CITY OR TOWN	
Maryland		Pr. George		Silver Spring	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Unknown		Unknown		No	
16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
579-42-1950D		Richard Tang (Son)		Same as #13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Uterus</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>2/21</i> , 19 <i>85</i> , to <i>3/9</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/9</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <i>Antonio G. Uly</i>		22c DATE SIGNED <i>3/9/85</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. Uly MD		22e ADDRESS 831 Univ Blvd E. # 25 S.S. Md 20903		22f DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY	
Burial		March 18, 1985		George Wash. Cemetery	
24 FUNERAL DIRECTOR NAME		24b DATE REC'D. BY REGISTRAR		24c REGISTRAR'S SIGNATURE	
J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002		MAR 18 1985		<i>Julia Davidson-Rodell</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF COMMERCE

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 0 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NANCY LEE CHURCHWELL			2a. DATE OF DEATH MONTH DAY YEAR MARCH 24 1985			2b. HOUR 9:30 P _M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 7 1938		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DISTRICT OF COLUMBIA UNITED STATES		7b. CITIZEN OF WHAT COUNTRY? MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY PRINCE GEO'S		13c. CITY OR TOWN DISTRICT HGTS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GUY HALL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH ELIZABETH DAY			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 578-48-1510			17. INFORMANT ADDRESS JAMES L. HALL, 1922 COUNTY ROAD, APT 203,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 20</u> , 19 <u>85</u> , to <u>MARCH 24</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 24</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u> LT MC USNR				DEGREE MD				22c. DATE SIGNED 26 MARCH 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.L. GRIFFEN, III, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 28 March 85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md			
24. FUNERAL DIRECTOR NAME ADDRESS Robert E Wilhelm Funeral Home				25a. DATE REC'D. BY REGISTRAR APR 02 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, it should be examined by the police.

030024



UNITED STATES

CONSTITUTION

JANUARY 4 1978

27

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

091123

1. DECEASED NAME (TYPE OR PRINT) EDITH G. CLARK			2a. DATE OF DEATH MONTH DAY YEAR 3 18 85			2b. HOUR 4 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 3 1888		6. AGE (IN YEARS LAST BIRTHDAY) 97 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MARYLAND		13b. COUNTY PR GEO		13c. CITY OR TOWN TAKOMA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT GARRISON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E BARNES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-2722		17. INFORMANT ADDRESS MARY F. WILLEY, 409 BOYD AVE T.P.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Atherosclerotic Heart Disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MOS. TO YRS

DUE TO, OR AS A CONSEQUENCE OF

(b)

Congestive Heart Failure

MOS.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Coronary Pulmonary Artery Atherosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>SPRING 6</u> , 19 <u>70</u> , to <u>MAY 18</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>MAY 18</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ALBERT H. GROLLMAN MD.				DEGREE MD.		22c. DATE SIGNED 3/19/85	
22d. PHYSICIAN'S NAME (Type or Print) ALBERT H. GROLLMAN MD.				22e. ADDRESS 1106 SPRING ST. SILVER SPRING MD 20910			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 21, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION COUNTY STATE Baltimore D.D. MD	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J. A. Walter				ADDRESS 259 CHASE BLVD DC		25. DATE REC'D. BY REGISTRAR MAR 26 1985	
26. REGISTRAR'S SIGNATURE Julia Swisher							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST VERNON MIDDLE EVERTT LAST CLARK VERNON CLARK		2a. DATE OF DEATH MONTH DAY YEAR 3 - 23 - 85		2b. HOUR 6 40 PM	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 12 - 10 - 08	6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HARDWICK, Vermont	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH SANDY SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIENDS HOUSE NSG HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STATIONARY ENG.	12b. KIND OF BUSINESS OR INDUSTRY N.Y. STATE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SANDY SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 17330 QUAKER LANE 20860
14. FATHER'S NAME FIRST MIDDLE LAST RALPH CLARK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA CLARKE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 089-01-2446		17. INFORMANT ADDRESS RUTH CLARK, WIFE, SAME AS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA LUNG APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM. 6 Mo.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEEKED, NOTED BY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 15 P.M. 3/23/85		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) this hospital attended the deceased from 3/23/85 to 3/23/85 and that in my opinion death occurred on the date and hour and from the causes stated.					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD		22b. ADDRESS OLNEY, MD 20832		22c. DATE SIGNED 3/23/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/24/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	
23d. LOCATION SUITLAND PG. MD.		24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASH., D.C. 20009			
25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

MEDICAL CERTIFICATION

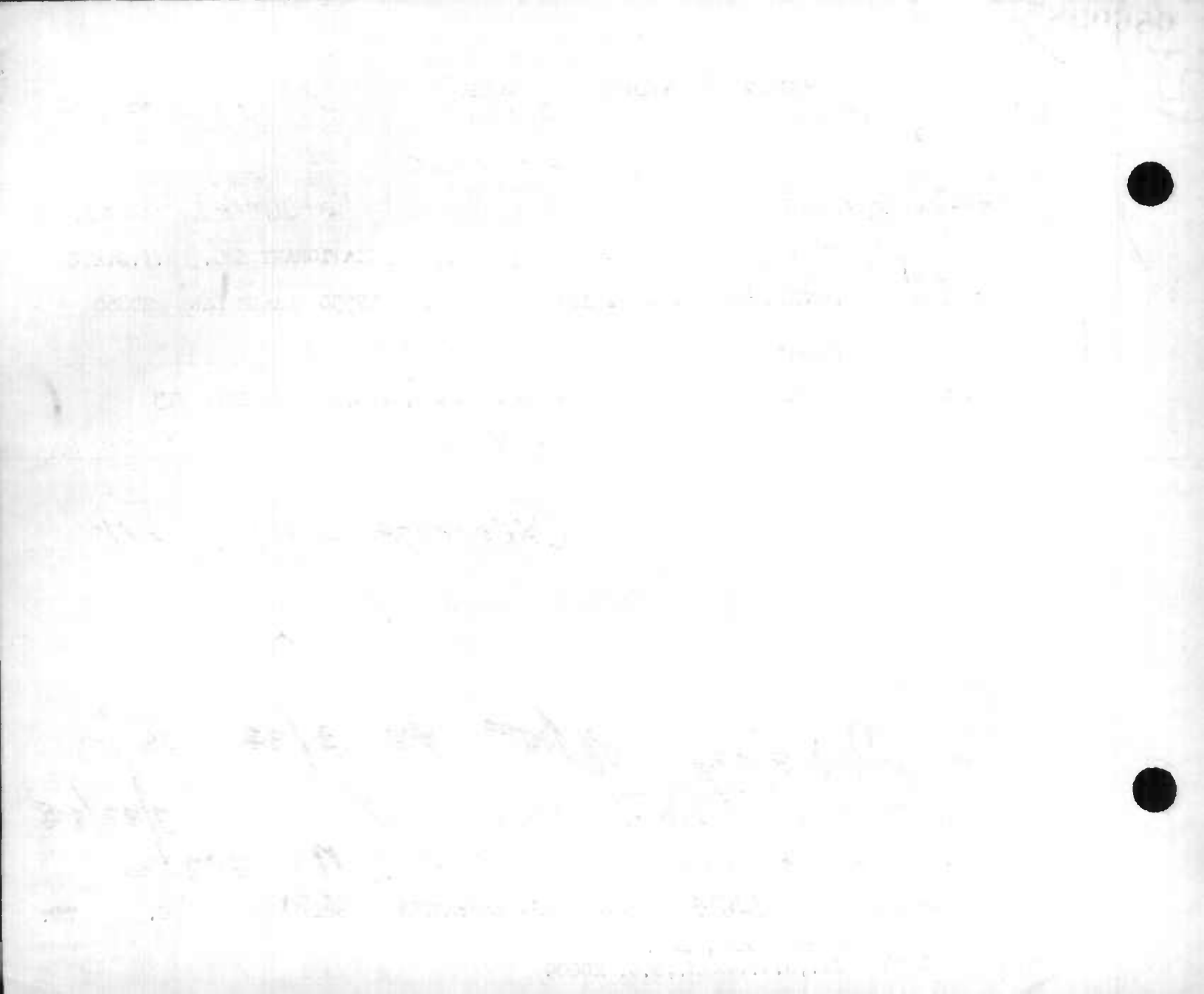
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



082137

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8508810

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ROY L. CLAY			2a. DATE OF DEATH MONTH DAY YEAR 3/9/85		2b. HOUR 3:35 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 9-7-1907		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SO. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTG. CO. MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY ENGINEERING
13a. STATE MD.		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANK CLAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA LAWSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 248-22-7249		17. INFORMANT MRS. MARIE J. CLAY (SAME AS #13)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION 3-8-85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Ulcer	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <u>the</u> (this hospital) attended the deceased from <u>MARCH 7</u> , 19 <u>85</u> , to <u>MARCH 9</u> , 19 <u>85</u> , that <u>he</u> (we) lost saw the deceased alive on <u>MARCH 9</u> , 19 <u>85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>he</u> (we) (did) (did not) view the body after death.			
22b. SIGNATURE Michael D. Sullivan MD		DEGREE MD	22c. DATE SIGNED 3/9/1985
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael D. Sullivan MD		22e. ADDRESS 1811 Prince Philip Dr Olney Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3-11-1985	23c. NAME OF CEMETERY OR CREMATORY UNION MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN COUNTY STATE UNION, UNION, S.C.
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC., SILVER SPRING		25a. DATE REC'D. BY REGISTRAR MAR 12 1985	
ADDRESS SILVER SPRING		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," show any injury, or other traumatic event, the medical examiner must be notified at once.

080040

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MALCOLM MIDDLE R. LAST CLIFT Malcolm R. Clift		2a. DATE OF DEATH MONTH DAY YEAR 3 15 85		2b. HOUR 1 A M	
3. SEX MALE M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 29 47	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 37 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Bethesda, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISC JOCKEY		12b. KIND OF BUSINESS OR INDUSTRY RADIO STA.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10504 WESTLAKE DRIVE 20817			
14. FATHER'S NAME FIRST RICHARD MIDDLE CLIFT LAST CLIFT		15. MOTHER'S MAIDEN NAME FIRST KATHERINE MIDDLE HOWARD LAST HOWARD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 214-48-5268		17. INFORMANT CHRISTINE S. CLIFT, WIFE, SAME AS ITEM #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BURGER'S DISEASE (THROMBOANGITIS) OBLITERANS DUE TO, OR AS A CONSEQUENCE OF (b) HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) MESENTERIC + HEPATIC ARTERY THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS. 6 WEEKS 6 WEEKS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION 1/10/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL ISCHEMIA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/7 1984 to 3/15 1985 , that (I) (we) last saw the deceased alive on 3/14 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.					
22b. SIGNATURE Louis Kozloff M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS KOZLOFF, M.D.		22e. ADDRESS 8218 WISCONSIN AVE. BETHESDA, MD. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/17/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA					
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASH., D.C. 20009		25a. DATE REC'D. BY REGISTRAR MAR 19 1985		25b. REGISTRAR'S SIGNATURE <i>Selia Davidson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

098133

1. DECEASED NAME (TYPE OR PRINT) VAUGHN BAKER COALE, SR.			2a. DATE OF DEATH MONTH DAY YEAR MARCH 31, 1985			2b. HOUR 8:58 a.m.			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAR. 6, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 19905 SPUR HILL DR. 20879	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE HOWARD COALE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL MARY SMITH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1969			17. INFORMANT ADDRESS NAOMI LEE COALE, 19905 SPUR HILL DR.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBROVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 22</u> , 19 <u>85</u> , to <u>MARCH 31</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 31</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W.A. Delacey</u> MD						DEGREE MD		22c. DATE SIGNED 31 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.A. DELACEY, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Apr. 3, 1985		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC		
24. FUNERAL DIRECTOR Hines/ Rinaldi Funeral Home						25a. DATE REC'D. BY REGISTRAR APR 2 1985		25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u>	

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STATE OF MARYLAND

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1. FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Naomi Ethel Cohee			2a. DATE OF DEATH MONTH DAY YEAR March 25, 1985		2b. HOUR 4:41A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 29 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Health Care N.H.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Howard			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma McMann		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-46-6460		17. INFORMANT ADDRESS James Cohee (Son) Same as 13e	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive lung disease		
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Arterial Stenosis		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/83 , 19 85 , to NOW , 19 85 , that (I) (we) lost saw the deceased alive on 3/19 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE X	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3-25-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark K. Li, M.D.		22e. ADDRESS 1721 Univ. Blvd. W. Wheaton, Maryland 20902	

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/27/85	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyattsville, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 26 1985	25b. REGISTRAR'S SIGNATURE <i>John W. Gordon</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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March 25, 1985

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U. S. Census Bureau, Bureau of Economic Analysis

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Frances Cohen</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>March 24 85</i>		2b. HOUR <i>2:20 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 17, 1909</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>75</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <i>Maryland Montgomery Kensington</i>				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE <i>3720 Nimitz Road (20895)</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Louis Silverstein</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ada Yuster</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>577-03-3024</i>		17. INFORMANT ADDRESS: <i>Maryland 20895</i> <i>Sandra Hackerman; 3720 Nimitz Road; Kensington,</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Congestive Heart Failure</i>		<i>1 week</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>		<i>Years</i>	

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypertension, severe

19a. DATE OF OPERATION <i>3/20/85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Severe Congestive Heart Failure</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/10/85</i> to <i>3/21/85</i> , that (I) (we) last saw the deceased alive on <i>3/20/85</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Hermon B. Segal MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hermon B. Segal MD</i>				22e. ADDRESS <i>10313 Georgia Ave Silver Spring Md</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3/24/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Gdn.; Falls Church; Fairfax; Va.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <i>DANZANSKY-GOLDBERG, MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852</i>				25a. DATE RECD. BY REGISTRAR <i>MAR 26 1985</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>Lena</u>			2a. DATE OF DEATH MONTH <u>3</u> DAY <u>20</u> YEAR <u>85</u>			2b. HOUR <u>10:30PM</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>12</u> DAY <u>25</u> YEAR <u>93</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>91</u> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Russia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County, MD.</u>			
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Hebrew Home of Greater Washington</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Seamstress</u>			
12b. KIND OF BUSINESS OR INDUSTRY <u>Dress Maker</u>									
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Rockville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <u>6121 Montrose Road (20852)</u>									
14. FATHER'S NAME FIRST <u>Louis</u> MIDDLE <u></u> LAST <u>Brodsky</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Rebecca</u> MIDDLE <u></u> LAST <u>Lenchuck</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>189-24-1938</u>		17. INFORMANT <u>Anna Lessin; 1220 Blair Mill Road; Silver Spg.</u>			ADDRESS <u>Maryland 20910</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

3 minutes

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 19 84</u> , to <u>3/20 85</u> , that (I) (we) last saw the deceased alive on <u>2/5 85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles Rosen MD</u>				DEGREE		22c. DATE SIGNED <u>3/21/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mark S Rosen, MD</u>				22e. ADDRESS <u>Silver Spring, MD</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/24/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sharon Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Springfield; Del. County, PA</u>	
24. FUNERAL DIRECTOR NAME <u>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</u> <u>1170 Rockville Pike; Rockville, Md. 20852</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 26 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Susan Davidson-Rodwell</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1910

CHIEFLY

20% COTTON FIBRE



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SYLVIA Funkhauser COMPTER			2a. DATE OF DEATH MONTH DAY YEAR 3-15-85			2b. HOUR 1 05 A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 4422 Strathmore Avenue 20896		
14. FATHER'S NAME FIRST MIDDLE LAST Victor Godfray Funkhauser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zora Trumpour						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-30-4490		17. INFORMANT ADDRESS Paul R. Compher, Sr. same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Congestive Heart Failure								3 days	
(c) Chronic and Acute Renal Failure								3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from March 11 , 19 85 , to March 15 , 19 85 , that (b) (we) lost saw the deceased alive on March 14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James E. Wilson, Jr. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3/15/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/18/85		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lovettsville, Virginia		
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852						25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE James E. Wilson, Jr.	

087078

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) MARY Clifford CONROY					2a. DATE OF DEATH MONTH DAY YEAR 3-19-85			2b. HOUR 7:35 PM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 29 1903		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Secretary		
13a. STATE Maryland					13b. COUNTY Prince George		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Clifford					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Tahney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 061-05-2812		17. INFORMANT Mary Ann Conroy				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Mar 15 19 85 , to Mar 19 19 85 , that (I) (we) last saw the deceased alive on MAR 19 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Bernard A. Fitzgerald					DEGREE MD		22c. DATE SIGNED 3-19-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD					22e. ADDRESS 217 UNIVERSITY BLVD EAST, SILVER SPRING MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 22 1985		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cath Ch Cem.		23d. LOCATION CITY OR TOWN COUNTY Bowie, Maryland 20841			
24. FUNERAL DIRECTOR NAME Beall Funeral Home					ADDRESS 16000 Annapolis Road Bowie, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 22 1985			
					25b. REGISTRAR'S SIGNATURE Ed. [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.



Chittora

Female Canadian April 22 1903 31

New York USA for Montgomery

2100 Spring Holy Cross Hospital Married Secretary

Maryland Prince George Greenfield x 22 Ridge Road 20770

Unknown Chittora 001-07-2412 Mary Ann Correy 10430 New York Road Bowie, Maryland

Small Internal Bone 10000 Maryland Road 10430 New York Road Bowie, Maryland

100031

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth A. Cotter			2a. DATE OF DEATH MONTH DAY YEAR 3. 29. 85		2b. HOUR 2-09 PM
3 SEX Female	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1908	6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Montgomery Chevy Chase			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13. STREET ADDRESS / ZIP CODE 3803 Woodbine Street/20815	
14. FATHER'S NAME FIRST MIDDLE LAST Albert J. McMurtrey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Lynch		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b SOCIAL SECURITY NO. 213-38-4017		17 INFORMANT ADDRESS Robert P. Cotter Dickerson, MD 20842			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ANOXIC BRAIN DAMAGE (c) CHRONIC OBSTRUCTIVE LUNG DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CONGESTIVE HEART FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 11b. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3-9-85, to 3-29-85, that (I) (we) lost saw the deceased alive on 3/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kempanna Sudhakar MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/29/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEMPANNA. SUDHAKAR, MD		22e. ADDRESS 7676 NEW HAMPSHIRE AVE. #410 CANGLEY PARK, MD 20783			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 2, 1985	23c. NAME OF CEMETERY OR CREMATORY St. Bernard's Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Scipio Center, New York		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814			25a. DATE REC'D. BY REGISTRAR APR 8 1985		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Paul J. Cotter			2a. DATE OF DEATH MONTH DAY YEAR March 6, 1985		2b. HOUR 12:25 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland	
10. CITY OR TOWN OF DEATH Dickerson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mouth of Monocacy Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer	12b. KIND OF BUSINESS OR INDUSTRY United States Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3803 Woodbine Street Chevy Chase, Maryland 20814	
14. FATHER'S NAME FIRST MIDDLE LAST James Cotter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Goode		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-60-9126		17. INFORMANT ADDRESS Robert P. Cotter (Son) Mouth of Monocacy Road Dickerson, Maryland 20842	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombocytopenia</u>	1 month
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Myelomonocyte leukemia</u>	1 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12 February</u> , 19 <u>85</u> , to <u>5 March</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>27 Feb.</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Richard M. Kaufman</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Mar. 6, 1985
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard M. Kaufman, M.D.		22e. ADDRESS 1145 19th Street, N.W. #605 Washington, D.C. 20036	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 9, 1985	23c. NAME OF CEMETERY OR CREMATORY Saint Bernard Catholic Church Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Scipio Center New York
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS 300 West Montgomery Avenue Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR MAR 8 1985 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "AT WORK", it should show any injury, or other traumatic event, the medical examination must be completed at the scene.

10-12-40



PEOPLES COTTON FIELD

CHATELAIN BOND



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 3 FOR OUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/76

FOR
1- STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Jay David Cramer						33 85			500			8 M			
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
male		white		1 1 63		22 YRS.						33 85		717 8 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania				United States								Montgomery Co., MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Gaithersburg				501 South Frederick Ave.				Maintenance Man				Shopping Mall			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				Zip	
Maryland		Montgomery		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		501 South Frederick Ave. #505C				20877			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Gerald Cramer				Marilyn Landman				Yes				187 44 7933			
17. INFORMANT				ADDRESS				17. INFORMANT				ADDRESS			
Gerald Cramer				106 South Marshall St.				Father York, Pa. 17402							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cardio pulmonary arrest															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b) Gun shot wound of head															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held on				Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED			
John Tauber				M.D. Deputy				Bethesda, MD.				3-3-85			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
John Tauber				8218 Wisconsin Ave											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				March 5, 1985		South Hill Hebrew Cemetery York				Pennsylvania					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 20814				MAR 8 1985				John Tauber							

①

MEO DR. TAUBER NOTIFIED & APPROVED

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Charlotte Reed Crampton										2a. DATE OF DEATH MONTH March DAY 14 YEAR 1985		2b. HOUR 11:15A	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH April DAY 17 YEAR 1929		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 		7b. IF UNDER 24 HRS HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5002 Dalton Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5002 Dalton Rd. 20815			
14. FATHER'S NAME FIRST Charles MIDDLE T. LAST Reed				15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE LAST Soper									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS Gilbert L. Crampton, Same as item 13.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration + Starvation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the cervix DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH About 1 month 6 months			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept 14 19 85 to March 19 85 , that (I) (we) last saw the deceased alive on Jan 14 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Chester Lee Roy Wagstaff				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 14, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chester Lee Roy Wagstaff				22e. ADDRESS Suite III, 1811 Prince Philip Dr., Uthly, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/18/1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN Arlington COUNTY Va. STATE 					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR MAR 21 1985		25b. REGISTRAR'S SIGNATURE John D. [Signature]					

BP _____

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 0 8 8 2 2

1. DECEASED NAME (TYPE OR PRINT) ELMER FRANKLIN CRIPPIN, JR.			2a. DATE OF DEATH MONTH DAY YEAR MARCH 21 1985		2b. HOUR 12:55 P					
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 26 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA			13b. COUNTY FAIRFAX		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6625 SPRING VALLEY DRIVE 22312	
14. FATHER'S NAME FIRST MIDDLE LAST ELMER FRANKLIN CRIPPIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BONNIE NORTON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-1966		17. INFORMANT DORIS R. CRIPPIN		ADDRESS 6625 SPRING VALLEY DRIVE,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PANLOBULAR EMPHYSEMA								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from MARCH 18 19 85 , to MARCH 21 19 85 , that (I) (we) lost saw the deceased alive on MARCH 21 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. S. Killeavy				DEGREE		22c. DATE SIGNED 22 MAR 85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. S. KILLEAVY, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/26/85		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION (CITY OR TOWN) COUNTY STATE ARLINGTON VIRGINIA				
24. FUNERAL DIRECTOR NAME ADDRESS DEMAINE FUNERAL HOME ALEXANDRIA, VIRGINIA				25a. DATE REC'D. BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

094023

Released by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/transfer permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: When 21 is marked as the cause of death, it is marked as the cause of death only if injury, or other traumatic event, the medical examiner has determined to be the cause of death.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Cunningham			2a. DATE OF DEATH MONTH March DAY 27 YEAR 1985			2b. HOUR 6:00 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH 3 - DAY 22 - YEAR 07		6. AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Humboldt, Iowa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) attorney	
12b. KIND OF BUSINESS OR INDUSTRY law		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7805 CONN AVE 20815	
14. FATHER'S NAME FIRST John LAST Cunningham		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE Johnson LAST Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578 36 0314		17. INFORMANT Marion Cunningham see # 13			

MEDICAL CERTIFICATION

C 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 min	
DUE TO, OR AS A CONSEQUENCE OF (b) diabetes mellitus				5 years	
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from September 19 84 to March 27 19 85 , that (I) (we) lost saw the deceased alive on March 27 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James F. McMurtry Jr. MD				22c. DATE SIGNED 3/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. McMurtry Jr. MD				22e. ADDRESS 6318 Democracy Blvd, Bethesda MD 20817	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1985 March. 29		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey		24b. ADDRESS Funeral Home's P.A. Bethesda, Maryland		24c. DATE REC'D. BY REGISTRAR APR 1 1985	
24d. REGISTRAR'S SIGNATURE Gabe Davidson-Randall					

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) August Dabrasky			2a. DATE OF DEATH MONTH 3 DAY 9 YEAR 85			2b. HOUR 9:14 A					
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 3 DAY 21 YEAR 85		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carnegie Hill Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (Ord.)			12b. KIND OF BUSINESS OR INDUSTRY Dept. of Defense		
13a. STATE Maryland		13b. COUNTY DC, Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 4708 46th St NW					
14. FATHER'S NAME FIRST George MIDDLE W LAST Dabrasky				15. MOTHER'S MAIDEN NAME FIRST August MIDDLE Schmeltz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-32-0601		17. INFORMANT Helen Auxier				ADDRESS Maryland 850 Sligo Ave Sil Sp.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) leukemia DUE TO, OR AS A CONSEQUENCE OF (c) leukemia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 30 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from Jan 19 84 to 9 Mar 19 85 , that (I) (we) last saw the deceased alive on 28 Feb 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not (did) not view the body after death.											
22a. SIGNATURE Paul T. Noons MD				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9 Mar 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul T. Noons				22e. ADDRESS 5000 Rockledge Dr Round Hill							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11 Mar 1985		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Robert E Wilhelm						ADDRESS Suitland Maryland		25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE Gelia Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

140189



Handwritten notes and markings, including a large 'X' and various symbols.



300 0 P NAM

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

074177 (Dr. Rogers 581) STATE OF MARYLAND 8825

FOR
1 - STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bessie Danoff			2a. DATE OF DEATH MONTH DAY YEAR March 5, 1985			2b. HOUR 4:31 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-12-05		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
13a. STATE Maryland		13b. CITY OR TOWN Silver Spring		13c. STREET ADDRESS / ZIP CODE 14508 Homecrest Road, #124 (20906)		12b. KIND OF BUSINESS OR INDUSTRY Home		
14. FATHER'S NAME FIRST MIDDLE LAST Morris Wolfe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Hersowitz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 578-60-4589		17. INFORMANT ADD Maryland 20853 Jerome Danoff; 14416 Woodcrest Drive; Rockville				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Embolus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Complete Heart Block								
19a. DATE OF OPERATION 3/5/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Complete Heart Block			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:31 P.M. 3/5/85 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/4 1985 to 3/5 1985, that (I) (we) lost the deceased alive on 3/5 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Richard N. Scott, M.D.				DEGREE		22c. DATE SIGNED 3/5/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 4801 MASS. AVE. N.W. WASH. D.C. 20016				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/85		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi; P.G.; Maryland		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR MAR 08 1985				
				25b. REGISTRAR'S SIGNATURE John Davidson-Rodella				

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WILKINSON



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

OK'd by
Dr. Rogers
094066

3-
A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be called on duty.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Lucy Davis</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Mar 12 1985</i>			2b. HOUR <i>12 A.M.</i>					
3. SEX <i>Female</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1-16-25</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>60</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>							
11a. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1143 Lockwood Drive 20904</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lorenzo Hines</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Baronie Hawkins</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>577 86 8832</i>		17. INFORMANT ADDRESS <i>226 Weymouth Street-Upper Marlboro.Md.</i> <i>Arlene Howell-daughter-</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Pulm Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Edema / Cardiogenic Shock</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Myocardial Infarction</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Ca of Colon</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION <i>N/A</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>N/A</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION STREET CITY OR TOWN COUNTY STATE									
22d. I certify that (1) this hospital attended the deceased from <i>3/12</i> 19 <i>85</i> to <i>3/12</i> 19 <i>85</i> , that (2) I saw the deceased and (3) I view the body after death.										22e. SIGNATURE <i>Philip Buttarone</i> MD DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <i>12 Mar 85</i>	
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>					23b. DATE <i>March 18, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harmony Memorial Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Landover, Md.</i>				
24. FUNERAL DIRECTOR NAME <i>Stewart</i>					25. MAR 28 1985 BY REGISTRAR 26. REGISTRAR'S SIGNATURE <i>Jana Davidson-Randall</i>								

10/10/1919
10/10/1919
10/10/1919

Let's remember to be generous
in our judgment

Let's remember to be generous
in our judgment

Let's remember to be generous
in our judgment

093107

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jesse S. DAWSON			2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1985		2b. HOUR P 1:03 P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 7 1888		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Stutler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Jahe Sherwood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-44-0404		17. INFORMANT ADDRESS Bette D. Gordon. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MINUTES</u> <u>Weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Possible gastrointestinal bleed, cysts</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>83</u> to <u>Mar 26</u> 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>March 15</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Alan R. Vinitzky</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/26/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VINITZKY, Alan R.</u>		22e. ADDRESS <u>1216 DARNESTOWN RD. GAITHERSBURG, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/28/1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u> <u>5130 Wisc. Ave., N.W. ash., D.C.</u>				25. DATE RECEIVED <u>MAR 29 1985</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		LAURENCE		A.		DEABLER		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Laurence A. Deabler						2a. DATE OF DEATH MONTH DAY YEAR 3 27 85			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 31, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7b. HOUR 11 08 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Gas Co.	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8511 Hunter Creek Trail 20854	
14. FATHER'S NAME FIRST MIDDLE LAST Ardell W. Deabler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna - Morse					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 047-10-7697		17. INFORMANT 13033 Daffymaid Dr. Susan Dixon Germantown, Md. 20874					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs. years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Other Fractures									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/27, 1984 to 3/27, 1985, that (I) (we) lost saw the deceased alive on 3/27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. H. Lyon		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/27/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Lyon		22e. ADDRESS 1811 P + Phily Dr, Olney Md 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MARCH 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Balt. Wash. Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P. George Md.			
24. FUNERAL DIRECTOR FRANCIS H. B ARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE John Davidson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARGARET M. DEENEY			2a. DATE OF DEATH MONTH 3 DAY 30 YEAR 85			2b. HOUR 1:15 P.M.	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH 11 DAY 24 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON GARDENS NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER	
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN BETHESDA	
14. FATHER'S NAME FIRST CHARLES MIDDLE DEENEY LAST DEENEY				15. MOTHER'S MAIDEN NAME FIRST ALICE MIDDLE MORGAN LAST MORGAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT JAY D. NEEL			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 6307 HAVILAND DR. 20817			
16c. ADDRESS 13505 GLENHURST RD.				16d. ADDRESS GAITHERSBURG, Md. 20878			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

DUE TO: **Hepatic Coma**

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO: **Hepatic failure**DUE TO: **OR AS A CONSEQUENCE OF****Liver disease due to alcohol**

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

24 hrs**1 month****5 months**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Anemia of chronic disease**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Oct 1984 to Mar 30, 1985 , that (1) (we) last saw the deceased alive on Mar 30, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George S. Kenton		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE S. KENTON		22e. ADDRESS 10620 GEORGIA AVE, SILVER SPRING, MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4-1-1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.				ADDRESS SILVER, SPRING, Md.		25a. DATE REC'D. BY REGISTRAR APR 03 1985	
				25b. REGISTRAR'S SIGNATURE [Signature]			



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGARET MIDDLE C. LAST DELMAR XXXXXXXXXX		2a. DATE OF DEATH MONTH DAY YEAR 3-2-85		2b. HOUR 8:18 P.M.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 3-18-1900	
6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 2 YRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 8615 PINEY BRANCH RD. 21403		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST SAMUEL MIDDLE LAST LIBBY		15. MOTHER'S MAIDEN NAME FIRST FLORENCE MIDDLE LAST PRYCE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 262-42-6685		17. INFORMANT PATRICIA KROENER		ADDRESS 10031 BENEFIELD RD., SILVER SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordio respiratory arrest (b) Cause C.V.A. (brain stem CVA) (c) Aspiration DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: b Drochle's mellitus.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NO: WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 3/3/85		21h. DATE SIGNED 3/3/85	
21i. I certify that (I) (this hospital, attended the deceased from saw the deceased alive on 3/2/85 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		21j. SIGNATURE Michael A. Rodero MD.		21k. ADDRESS 831 Univ. Blvd. S. Spring Md	
21l. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Rodero MD.		21m. ADDRESS 831 Univ. Blvd. S. Spring Md		21n. DATE SIGNED 3/3/85	
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE MAR. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VA		23e. DATE REC'D. BY REGISTRAR MAR 7 1985		23f. REGISTRAR'S SIGNATURE J. Davidson-Randall	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH A. DEVINE										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 9 1985				2b. HOUR 0240	
1. SEX Male		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 11 26 64		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 9 1985		2d. HOUR 0220			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Switzerland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH POTOMAC				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9100 RIVER RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT				12b. KIND OF BUSINESS OR INDUSTRY College			
13a. STATE MD				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20854 9204 FALLS BRIDGE LN					
14. FATHER'S NAME FIRST MIDDLE LAST James T. Devine						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rita Walsh									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-58-9339		17. INFORMANT ADDRESS James T. Devine, same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE TRAUMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2200 3 9 1985				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) CAR HIT TREE							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9100 RIVER RD Potomac MONTGOMERY MD							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <i>Francis C. Meyer</i>				TITLE (SPECIFY) Sgt				M.D. Francis C. Meyer				DATE SIGNED 3-9-85			
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Meyer				ADDRESS 8200 Wisconsin Ave Bethesda MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 12, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel's Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS Homes, P.A. Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marion Prentice Dickson			2a. DATE OF DEATH MONTH DAY YEAR 3-3-85			2b. HOUR MIN. 0835		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 3, 1889		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 95		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Own Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5 Duncan Branch Court 20850						
14. FATHER'S NAME FIRST MIDDLE LAST James Prentice				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Wilson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 376-05-0569		17. INFORMANT ADDRESS Robert Gebhardtsbauer, same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Feb 25 , 19 85 , to Mar 3 , 19 85 , that (I) (we) last saw the deceased alive on Mar 2 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Robert T. Thibadeau				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/3/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU				22e. ADDRESS ROCKVILLE, MD 20852				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Crementation		23b. DATE March 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR MAR 8 1985				
25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randese</i>								

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "WHILE AT WORK" or "NOT WHILE AT WORK", the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Kathleen</i>		FIRST <i>Kathleen</i> MIDDLE <i>P.</i> LAST <i>Dietz</i>		2a. DATE OF DEATH MONTH <i>3-</i> DAY <i>21</i> YEAR <i>95</i>		2b. HOUR <i>11:15 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH <i>3</i> DAY <i>18</i> YEAR <i>94</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Richmond, Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery Co., MD.</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Colonial Village</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House Mother</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Univ of W. Va.</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>Delts.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Ellis</i> MIDDLE <i>Ira</i> LAST <i>Parrish</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Jennie</i> MIDDLE <i>Nelson</i> LAST <i>Vaughan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>232-56-6604</i>	
17. INFORMANT		18. JENNIE D. MOSS (daughter) Same as 13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Advanced age, Chronic Aortic Aneurysm

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>did</i> <input checked="" type="checkbox"/> <i>did not</i> <input type="checkbox"/> view the body after death. <i>15 Jan 85</i> to <i>31 March 85</i> , that (I) <i>am</i> <input checked="" type="checkbox"/> <i>am not</i> <input type="checkbox"/> the deceased alive on <i>20 March 1985</i> , and that in (my) <i>own</i> <input checked="" type="checkbox"/> <i>other</i> <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT) <i>John F. Brennan, Jr., M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>21 March 85</i>	
22d. ADDRESS <i>3415 Hamilton St., Hyattsville, MD 20782</i>							

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>25 Mar 85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>East Oak Grove Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Morgantown</i> COUNTY <i>West Virginia</i> STATE	
24. FUNERAL DIRECTOR NAME <i>Capitol Funeral Service, Falls Church, VA</i> ADDRESS				25a. DATE REC'D BY REGISTRAR <i>MAR 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Gina Durden</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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At the same time, the *Journal of the American Medical Association* (JAMA) has been publishing a series of articles on the topic of "The Role of the Physician in the Management of the Patient with a Chronic Disease." These articles have been published in the following issues:

086030

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSE DEJESUS DIZON Jr.		2a. DATE OF DEATH MONTH DAY YEAR MARCH 21 1985		2b. HOUR 9:45 P_M	
3. SEX MALE	4. RACE PHILLIPINO	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 9 1941		6. AGE (IN YEARS-LAST BIRTHDAY) 43 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PHILLIPINES	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
13a. STATE MARYLAND		13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOSE CRUZ DIZON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOLEDAD DEJESUS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1963-1984		17. INFORMANT ADDRESS LIWAYWAY A. DIZON, 5682 STEVEN FOREST ROAD, 21045	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: CARDIORESPIRATORY ARREST IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from MARCH 20, 19 85 , to MARCH 21, 19 85 , that (I) (we) last saw the deceased alive on MARCH 21, 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Burn (76)		DEGREE MD		22c. DATE SIGNED 22 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. L. FLAX, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/85		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN Arlington		COUNTY Virginia		STATE	
24. FUNERAL DIRECTOR Leroy H. & Russell C. Witzke, Funeral Homes P.A. 5555 Twin Knolls Road, Columbia, Md. 21045		25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE Richard R. Riddell	

BP

086030



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN THOMAS DONAHUE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 22, 1985		2b. HOUR 1:40 PM						
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JAN 9, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. UNDER 1 YEAR MONTHS DAYS 85		8. UNDER 24 HRS HOURS MIN. 85	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL PRE HEALTH CARE CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY D.C. GOVT.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1506 COLUMBIA AVENUE 20850			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES DONAHUE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REGINA CALLAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-09-0271		17. INFORMANT ADDRESS MARY ELLEN INNOCENTI SAME AS 13 DAUGHTER							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Diseases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>mos</u> <u>yrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Cerebral Vascular Accident</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>84</u> , to <u>March</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Raymond T. Benack</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>3/22/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND T. BENACK				22e. ADDRESS 4115 COLIE DRIVE, WHEATON, MARYLAND 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR APR 1 1985				25b. REGISTRAR'S SIGNATURE <u>John F. B. B. B.</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

BP

094017

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as not applicable, the medical examiner must be notified by the funeral director.

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082142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8508836

1 - FOR
STATE
REGISTRAR

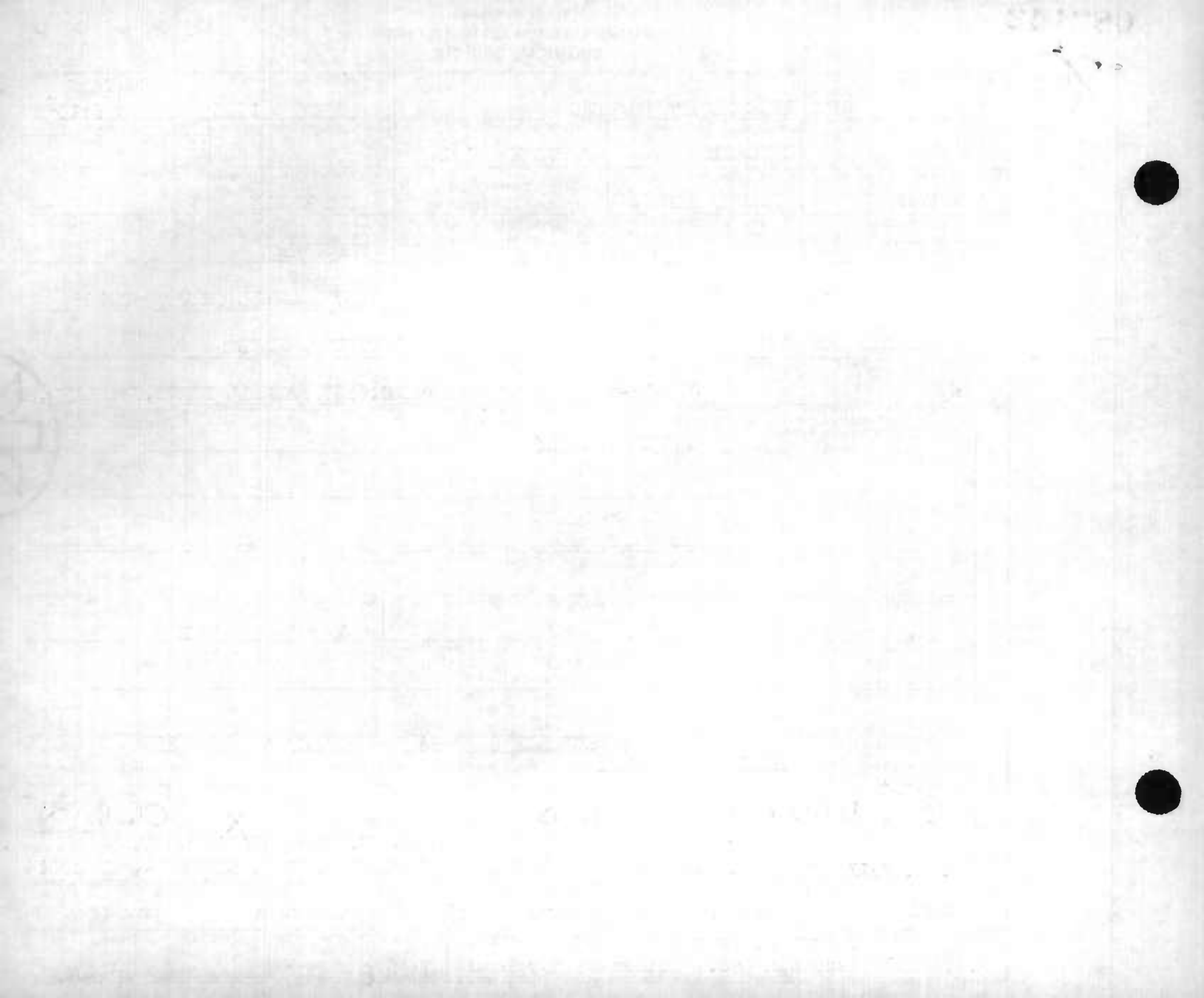
REG. NO.

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CATHERINE REGINA DONDERO					MARCH 4 1985					6:10 ^P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		JANUARY 8 1920		65 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NEW YORK		UNITED STATES				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		NAVAL HOSPITAL				HOUSEWIFE					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6267 MAXWELL DRIVE 20746			
MARYLAND		PRINCE GEO'S		SUITLAND							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST WALTER DONOVAN					FIRST MIDDLE LAST KATHRYN SCHAYER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO					070-12-5455		WALTER DONDERO, 6267 MAXWELL DRIVE, SUITLAND, MD 20746				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANDIDA SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 6</u> , 19 <u>84</u> , to <u>MARCH 4</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>MARCH 4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. S. Killeavey</i>						DEGREE MD			22c. DATE SIGNED 06 Mar 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. S. KILLEAVEY, LT, MC, USNR						22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE		
Burial			March 8, 1985		Calverton National		Calverton		New York		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Ave., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John F. ...</i>			
						MAR 8 1985					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



088125

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 3 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT E. DOUGHERTY			2a. DATE OF DEATH MONTH DAY YEAR MARCH 19, 1985		2b. HOUR 3:20 PM	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 10, 1917		
6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9704 ARMISTEAD ROAD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER		12b. KIND OF BUSINESS OR INDUSTRY MAIL PARTICLE BOARD ASSOC.		13a. STATE MARYLAND		
13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 9704 ARMISTEAD ROAD 20903		14. FATHER'S NAME FIRST MIDDLE LAST EMMETT GEORGE DOUGHERTY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET CONROY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 578-22-9782		17. INFORMANT ADDRESS SON 6917 WOODSIDE PLACE R. KEVIN DOUGHERTY CHEVY CHASE, MD. 20815		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rectal adenocarcinoma with liver metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR Sept 19 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6525 BEL CREST ROAD, HYATTSVILLE, MARYLAND		
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 83 to March 19 85 , that (I) (we) last saw the deceased alive on 3-8-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Kai-Yin Yeung, MD		22c. DATE SIGNED 3-19-85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kai-Yin Yeung, MD		
22e. ADDRESS 6525 BEL CREST ROAD, HYATTSVILLE, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/21/85		
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		23e. DATE REC'D. BY REGISTRAR MAR 26 1985		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR MAR 26 1985		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

МАТЕРИ

101108

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 3 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles E. Doye			2a. DATE OF DEATH MONTH DAY YEAR 3-30-85		2b. HOUR 2049 M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR JAN. 22, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (LAST WORK FOR MOST OF WORKING LIFE) Backhoe Oper.	12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Montg. 13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12609 Tobytown Dr. 20854		
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE DOYE		15. MOTHER'S MAIDEN NAME MIDDLE LAST Irene Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. 214-28-3487	17. INFORMANT ADDRESS Eleanor Doye (wife) 223 N. Adams St. Rockville Md. 20850			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) bilateral adrenal hemorrhage & pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) miconodular cirrhosis, liver					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 3/29 , 19 85 , to 3/30 , 19 85 , that (1) (we) lost saw the deceased alive on 3/30 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ira Paul Kretzky		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ira Paul Kretzky		22e. ADDRESS 2101 Med PK Drive Silver Spring, Md 20902			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-6-85	23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850		25. DATE REC'D. BY REGISTRAR APR 04 1985	
				25b. REGISTRAR'S SIGNATURE Julia Davidson	

Male

101102

101102

101102

DHMH - 16 60M 7/84
(VRA 15, 4)

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ALBERT Louis DUERR				2a. DATE OF DEATH MONTH DAY YEAR 3 28 85				2b. HOUR MIN. 1:45P				
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 1 28 91		6. AGE (IN YEARS LAST BIRTHDAY) 94		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		7b. IF UNDER 24 HRS HOURS MIN. MD		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery						
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS				12a. USUAL OCCUPATION (TYPE OF) Retired Book Binder			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY MONT.		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5112 Yosemite Drive 20853		
14. FATHER'S NAME FIRST MIDDLE LAST Adam Duerr				15. MOTHER'S MAIDEN NAME Mary Louise Pröll								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 1		17. INFORMANT Ila M. Tanner same as 13e		ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Capillary pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Arteriosclerotic cardiovascular disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 2/22 19 85 , to 3/28 85 , that (I) (we) last saw the deceased alive on 3/28 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Myron A. Lenkin						DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON LENKIN						22e. ADDRESS 2309 SHOREFIELD RD WHEATON, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/30/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d. LOCATION Suitland, Maryland STATE				
24. FUNERAL DIRECTOR Thyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR APR 3 1985		25b. REGISTRAR'S SIGNATURE John Darden-Hendell				

1941-1942

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other
1941-1942
other

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098128

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (1))

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THOMAS BUCHANAN DUGAN <i>Thomas Buchanan Dugan</i>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 28 85			2b. HOUR 11 48 AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 18 02	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 28 85	7d. HOUR 11 48 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10401 GROSVENOR PLACE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAR ADMIRAL RET.		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN BETHESDA				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10401 GROSVENOR PLACE 20852		
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS BUCHANAN DUGAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERALDINE RICHMOND WESSELLS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1918-1952		17. INFORMANT (GRANDDAUGHTER) ELIZABETH FROST, 4106 ELBY ST., SIL.SPG., MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) metastatic carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Tauber</i>		TITLE (SPECIFY) M.D. <i>Deputy</i>			MEDICAL EXAMINER		DATE SIGNED 3-28-85	
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		ADDRESS 8218 Wisconsin Ave Bethesda						
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 4/1/85		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009				25a. DATE REC'D. BY REGISTRAR APR 2 1985		25b. REGISTRAR'S SIGNATURE <i>Richard Rapp</i>		

— 1 —

151-1111

100028

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6508841

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances I. Dumas			2a. DATE OF DEATH MONTH DAY YEAR March 31, 1985			2b. HOUR 11am M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Rollins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Brewer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 020 26 2679a		17. INFORMANT ADDRESS Beatrice H. Stengell, see # 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis	20 years
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 3/31/85			
22a. I certify that (I) (the hospital) attended the deceased from 3/25/85 to 3/31/85 , that (I) (we) last saw the deceased alive on 3/25/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Henry C. Scruggs</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/1/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs, MD				22e. ADDRESS 5413 Cedar Lane, Bethesda, Maryland. 20814			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 3, 1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR APR 8 1985		25b. REGISTRAR'S SIGNATURE <i>G. A. Davidson-Rodriguez</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE 5T., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

850001

3085041

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CELESTIA A. DUNN			2a. DATE OF DEATH MONTH DAY YEAR 3 15 85			2b. HOUR 1 P M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 13, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired		12b. KIND OF BUSINESS OR INDUSTRY C & P Tel. Co.	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Montgomery Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1701 Evelyn Drive 20852				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Pessagano			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aemilia Reteliata						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577 01 1838		17. INFORMANT ADDRESS Adrienne M. Dunn same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 M. 70 yrs 3 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/1/84 19 84 to 15 Feb 19 85 , that (I) (we) lost saw the deceased alive on 15 Feb 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 15 Feb 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Lebowitz, MD			22e. ADDRESS 1120 New Hampshire Ave S, Wash						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/19/85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL HOME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852						25a. DATE REC'D. BY REGISTRAR APR 20 1985		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02530 C 1401

TABLE 1

1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Edward M Eckert			2a DATE OF DEATH MONTH DAY YEAR March 26 1985			7b HOUR 1205 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 8 1918		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7a UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7c CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH S.S.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13825 Castle Blvd.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Grand Union		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Mont.		13c CITY OR TOWN S.S.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Dana Eckert				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Barkley					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None			16b SOCIAL SECURITY NO. 159 16 1553		17 INFORMANT 9096 Foxbridge Drive 21791 Wayne Eckert (Son) Union Bridge, Md.				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Dec 3/25, 19 85, to March 26, 19 85, that (I) (we) last saw the deceased alive on 3/25, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b SIGNATURE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> MARTIN C. SHARGEL						22c DATE SIGNED 3/26/85			
23a BURIAL, CREMATION, REMOVAL 13a Burial						23b DATE 3/28/85		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d LOCATION CITY OR TOWN COUNTY STATE S.S. Mont Md.									
24 FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.						25a DATE REC'D. BY REGISTRAR MAR 29 1985		25b REGISTRAR'S SIGNATURE John Harrison Wendell	

MEDICAL CERTIFICATION

03310

M



1912

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Handwritten text, possibly a signature or date, appearing as a horizontal line of script.

Handwritten text, possibly a signature or date, appearing as a horizontal line of script.



081956

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elizabeth Soott Ashlin Eldridge			2a. DATE OF DEATH MONTH DAY YEAR 3 11 85		2b. HOUR 5³⁰ PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 26 1889		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Danville, Va.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Silver Spring Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cherry Chase Ret. + Nrs. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary		12b. KIND OF BUSINESS OR INDUSTRY Government
13a. STATE Washington, D.C.		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Granville H. Ashlin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Graveley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 577 54 4534		17. INFORMANT Mary E Rives		ADDRESS 1676 Carlyle Dr., Apt. B., Crofton, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) **cerebrovascular accident**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 days**40 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

myeloma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4 Sept 19 79 to 11 March 19 85 , that (I) (we) lost saw the deceased alive on 4 March 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Lawrence H. Schainker MD	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11 Mar 85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence H. Schainker		22e. ADDRESS 5401 Western Ave, N.W. Wash, D.C.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/11/85	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.		25a. DATE REC'D. BY REGISTRAR	
5130 Wisc. Ave., N.W. Wash., D.C.		25b. REGISTRAR'S SIGNATURE John F. ...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8845	
1. DECEASED NAME (TYPE OR PRINT) George J. Ellis, Sr.						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 10 1985		2b. HOUR 1052 AM			
1a. SEX Male		1b. RACE White		3. DATE OF BIRTH MONTH DAY YEAR 9 25 02		4. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.		5. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		6. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIAN		12b. KIND OF BUSINESS OR INDUSTRY MEDICINE			
13a. STATE MD						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel S. Ellis						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anne C. Morgan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-46-1053A		17. INFORMANT William M. Ellis, Son ADDRESS 6 Hartman Ct., Potomac, MD 20854					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRYTHMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) YKS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION -				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? -				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 PM 3 10 1985				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5302 Kenwood Ave Chevy Chase Mont. MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Francis C. Mayhew						TITLE SPECIFY Dept		M.D. Dept		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayhew						ADDRESS 820 Wisconsin Ave Bethesda MD		DATE SIGNED 3/11/85		20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/13/85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.				23d. LOCATION CITY STATE Silver Spring, MD	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc., 5130 Wisconsin Ave., N.W., Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR MAR 14 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Rendell			

086097

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIRGINIA DALE ESCHENBURG-SEARLE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 20 1985		2b. HOUR 3:40 P.M.		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 14 1943		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COLORADO		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY JUDICIAL	
13a. STATE DISTRICT OF COLUMBIA		13b. COUNTY WASHINGTON, D.C.		13c. STREET ADDRESS / ZIP CODE 3715 LIVINGSTON ST. NW 20015		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN M. ESCHENBURG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILLI-FAN MAYO		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 522-58-3964		17. INFORMANT ADDRESS ROBERT A. SEARLE, 3715 LIVINGSTON STREET, NW					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 3 , 19 85 , to MARCH 20 , 19 85 , that (I) (we) lost saw the deceased alive on MARCH 20 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE T. G. RAINEY, CDR, MC, USNR		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-22-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. G. RAINEY, CDR, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3/23/85		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION SUITLAND PG. MD.	
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASHINGTON, D.C. 20009				25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rossell</i>	

MEDICAL CERTIFICATION

VO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Paged may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified or contacted.

080037

CLIMATE-DEPARTMENT

INSTRUMENT



93819 NOTION 2002

DAVID M. WATKINS

UNABLE TO REPLY WITHIN 30 DAYS

1904 T. G. WATKINS, JR., 1000 S. 10th St., St. Paul, Minn.

0870320

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CATHÉRINE G. FAIRALL			2a. DATE OF DEATH MONTH DAY YEAR MARCH 16, 1985		2b. HOUR 4:58 PM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 2, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH KENSINGTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4212 GLENRIDGE STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. CITY MONTGOMERY	13c. CITY OR TOWN KENSINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4212 GLENRIDGE STREET 20895
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT S. GOURLAY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE W. WALL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-38-4651		17. INFORMANT SON ADDRESS 122 MARK DAVID BLVD. MEADE C. FAIRALL, JR. CASSELBERRY, FLORIDA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SQUAMOUS CELL CARCINOMA OF LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hr 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>CONGESTIVE HEART FAILURE / PULMONARY OSTEOARTHRITIS</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10 JAN</u> , 19 <u>85</u> , to <u>16 March</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>16 March</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Eugene P. Libre M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 16 March 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE M.D.		22e. ADDRESS 10400 Connecticut Ave NEWINGTON, MD. 20895			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/20/85	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS			25a. DATE REC'D. BY REGISTRAR MAR 22 1985		
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

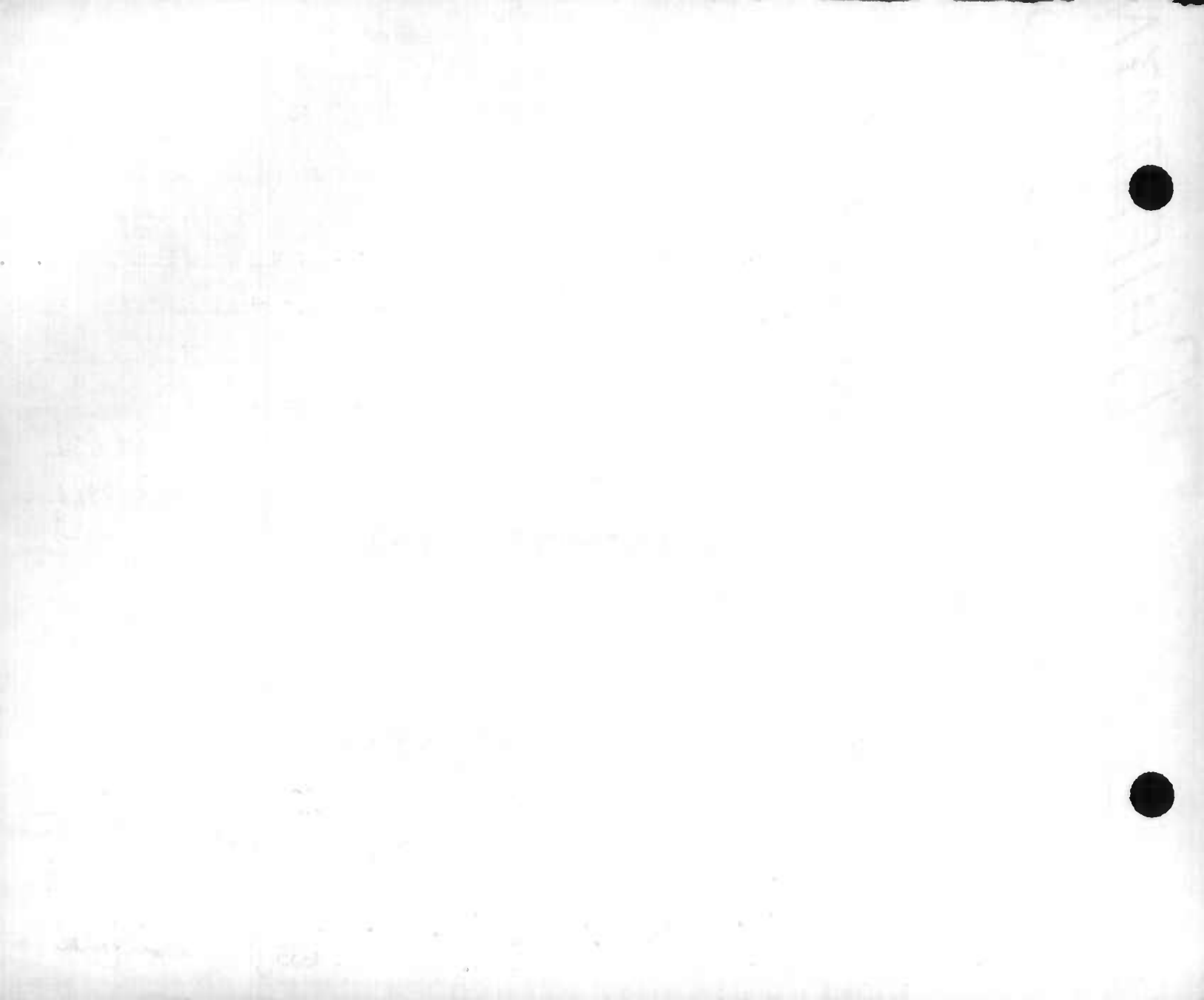
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Falcone			2a. DATE OF DEATH MONTH DAY YEAR 3/7/85		2b. HOUR 2:30 pm M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 10 00		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY Izzo Constr. Co.		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1500 Stateside Drive 20903	
14. FATHER'S NAME FIRST MIDDLE LAST Phillip Falcone			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucia Maiatico							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Margaret Falcone-wife-(same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESP FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PEPIS DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia FROST CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
								3 days		
								4 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 6:00 AM to 1:00 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE JK Elman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 6525 Belcrest Rd, Hyattsville, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Catholic Cem. Glassboro		23d. LOCATION CITY OR TOWN COUNTY STATE New Jersey			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAR 11 1985				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, or other traumatic event, the medical examiner must be notified.



081074

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA ROSE FARRELL			2. DATE OF DEATH MONTH MARCH DAY 15 YEAR 1985			2b. HOUR 1:15 P M	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH January DAY 31 YEAR 1896		6 AGE (IN YEARS LAST BIRTHDAY) 89	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY H ome	

USUAL RESIDENCE (IF IN HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Montgomery Olney		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 18430 Brooke Grove Rd. 20832	
14 FATHER'S NAME FIRST Charles MIDDLE — LAST Murphy			15 MOTHER'S MAIDEN NAME FIRST Bridget MIDDLE — LAST Donahue			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		
16b. SOCIAL SECURITY NO 112-26-1140			17 INFORMANT Charles T. Farrell			27 ADDRESS Box Lane Commack, N.Y. 11725		

18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF ABCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO, OR AS A CONSEQUENCE OF (c) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Oligemic Brain Syndrome			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 3/15 to 3/15 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)		22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 3/15/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. Barber		22e. ADDRESS 18111 P+P Hwy Dr., Olney Md 20832					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 19, 1985		23c. NAME OF CEMETERY OR CREMATORY L.I. Nat. Cemetery		23d. LOCATION CITY OR TOWN Pinelawn COUNTY Suffolk STATE N.Y.	
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24 FUNERAL DIRECTOR NAME Francis H. Barber		ADDRESS Laytonsville, Md. 20879		25a. DATE REC'D BY REGISTRAR MAR 24 1985		25b. REGISTRAR'S SIGNATURE [Signature]	
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BP.

DHMH-16 25M
(VRA 15, 4) 1/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", it shows any injury, or other traumatic event, the medical examiner must be notified at once.

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

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085003

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST JOSEPH		MIDDLE		LAST FAZZINO		2a DATE KNOWN OF DEATH		MONTH DAY YEAR		2b 1988	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS		12b KIND OF BUSINESS OR INDUSTRY		12c	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 16 PART 1 OR PART 2)		21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f LOCATION STREET		21g CITY OR TOWN		21h COUNTY		21i STATE		22a I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN		23e COUNTY		23f STATE		23g DATE REC'D. BY REGISTRAR	
24 FUNERAL DIRECTOR		24a NAME		24b ADDRESS		24c CITY OR TOWN		24d COUNTY		24e STATE		24f REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Carcinoma of Bone
DUE TO, OR AS A CONSEQUENCE OF
(c) 5 yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
None

19a DATE OF OPERATION
None

21a EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21d INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK ☐ AT WORK ☐

22a I certify that I took charge of the remains described above, held an
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S NAME
(TYPE OR PRINT)

John S. Rogers, DME

TITLE (SPECIFY)

M.D. Dep. MEDICAL EXAMINER

DATE
SIGNED

March 15/1985

ADDRESS 1919 Seminary Rd. Silver Spring, Md.

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b DATE 3-18-1985 23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery 23d LOCATION CITY OR TOWN Silver Spring COUNTY Montgomery STATE Md
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 24a NAME 11800 N.H. Ave. 24b ADDRESS Silver Spring, Md. 24c CITY OR TOWN MAR 20 1985 24d COUNTY Montgomery STATE Md 24e REGISTRAR'S SIGNATURE Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter D. Ferris			2a. DATE OF DEATH MONTH DAY YEAR March 17, 85		2b. HOUR 1:00pm
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 24, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 68
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11399 COLUMBIA PIKE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. - PRINTER	12b. KIND OF BUSINESS OR INDUSTRY POSTAL SERVICE	
13a. STATE Md.			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST NORMAN WILLIS FERRIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA EMMA STOWE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-03-4356		17. INFORMANT JAMES A. FERRIS (SAME AS #13)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of LungAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 yrs.**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **Oct. 19, 54** to **March 17, 1985** that (I) (we) lost
saw the deceased alive on **March 11, 1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (Type) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐**JOSEPH T. WALLACE, M.D.****5272 RIVER ROAD
BETHESDA, MD. 20814**23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL23b. DATE
3/20/198523c. NAME OF CEMETERY OR CREMATORY
AUSTIN CEMETERY23d. LOCATION
CITY OR TOWN COUNTY STATE
KITTY HAWK DARE, N.C.

24. FUNERAL DIRECTOR

NAME

ADDRESS

W. W. CHAMBERS CO. INC. SILVER SPRING, MD.

25a. DATE PREPARED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAR 22 1985

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000

March 17 1932

Dear Sirs

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.

I am sorry that I cannot give you a more definite answer at this time, but I am sure that you will understand my position.

I am, Sir, very respectfully,
Yours truly,
[Signature]

Very truly yours,
[Signature]

Enclosed for you are two copies of the report of the committee on the subject of the proposed amendment to the constitution of the State of New York.

I am, Sir, very respectfully,
Yours truly,
[Signature]

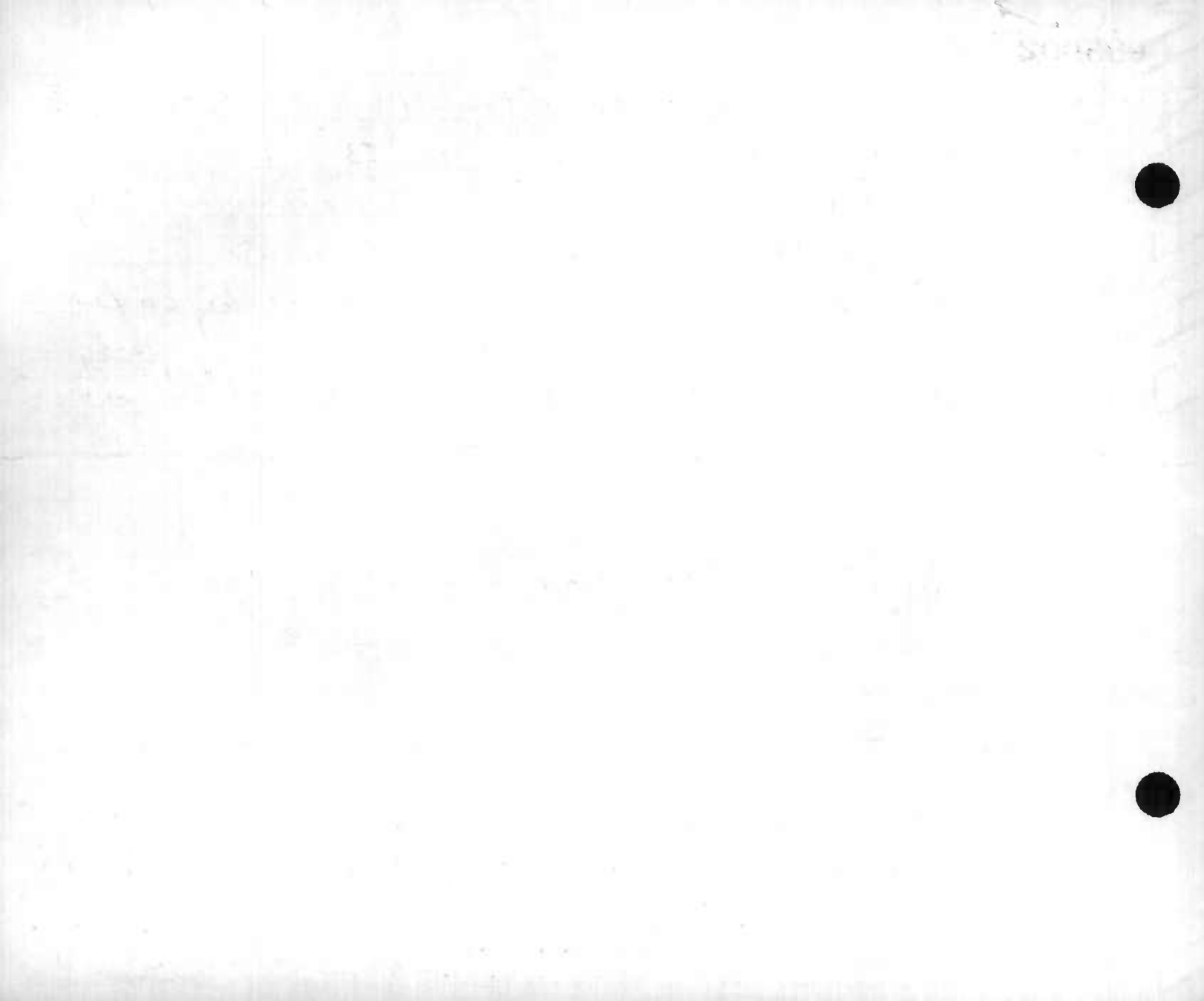
085002

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice Gertrude Fitzgerald</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/18/85</i>		2b. HOUR MIN. <i>6:28 P.M.</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 12 31</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>53</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Boston, Mass</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>	
10. CITY OR TOWN OF DEATH <i>Olney, MD</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4308 Mt. Olney Ln. Olney, MD</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Olney</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William F. Clark</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice G. Hardy</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>023-244891</i>		17. INFORMANT ADDRESS <i>Edward F. Fitzgerald 4308 Mt. Olney Ln. Olney MD 20832</i>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Cell Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Recurrent, bilateral lungs, liver metastasis. Hypercalcemia</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>84</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>Nov 84</i> to <i>18 Mar 85</i> , that (I) (we) last saw the deceased alive on <i>13 Mar 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>Donald E. Dillon MD</i>				DEGREE		22c. DATE SIGNED <i>19 Mar 85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald E. Dillon MD</i>				22e. ADDRESS <i>2901 Olney-Sandy Spr. Rd Olney MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>March Sat. 23, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Needham Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Needham Norfolk Mass.</i>	
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>20 1985</i>			
25b. REGISTRAR'S SIGNATURE <i>Richard Rinaldi</i>							

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ARTHUR H. HERBERT FOGELMAN										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 8 19 85	
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 1 25 30 6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.										2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 8 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICAL ENGINEER -			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. CITY OR TOWN MONTGOMERY			13c. CITY OR TOWN CHEVY CHASE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Julius - Fogelman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances - Renner			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ---		
17. INFORMANT ADDRESS Juanita Fogelman, Same address as			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE TRAUMA DUE TO, OR AS A CONSEQUENCE OF (b) 8138 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c) ---			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 DAYS			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). MULTIPLE SCLEROSIS		
19a. DATE OF OPERATION 3-1-85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? INTRACRANIAL HEMORRHAGE			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. HOUR A.M. MONTH DAY YEAR 1200 P.M. 3 28 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) HIT BY BUS IN MOTORIZED WHEELCHAIR					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) STREET			21f. LOCATION STREET CITY OR TOWN COUNTY STATE WILLARD AVE CHEVY CHASE MONT MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACQUA SIGNATURE Francis J. White M.D.						TITLE (SPECIFY) DIST			DATE SIGNED 3/8/85		
EXAMINER'S NAME (TYPE OR PRINT) Francis J. White						ADDRESS 6200 Wisconsin Ave Bethesda MD			20814		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/10/85			23c. NAME OF CEMETERY OR CREMATORY Wash. Heb. Cong. Mem. Pk.			23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.		
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc. 15130 Wisconsin Ave, N W, Washington, DC						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE John E. ...		

White

1931
CITIZEN



2130 Locust Ave., Washington, D.C.
JAMES E. HAYES
JAMES E. HAYES
JAMES E. HAYES

08244

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RONALD WESLEY FOLTZ JR.			2a DATE OF DEATH MONTH DAY YEAR MARCH 6, 1985			2b HOUR A M 11:30	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JAN 31, 1967		6 AGE (IN YEARS LAST BIRTHDAY) 18 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH		12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Student		12b KIND OF BUSINESS OR INDUSTRY Education	
13a STATE (NAME OF COUNTY) PENNSYLVANIA Dauphin				13b CITY OR TOWN Middle Paxton		13c STREET ADDRESS / ZIP CODE 1230 PETERS MT ROAD 17018	
14 FATHER'S NAME FIRST MIDDLE LAST Ronald Wesley Foltz Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Morgan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A		17 INFORMANT (FATHER) RONALD W. FOLTZ, SR		ADDRESS SAME AS ABOVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC SARCOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months							
19a DATE OF OPERATION August 20, 1984		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Metastatic Sarcoma		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from AUGUST 2, 1984 to MARCH 6, 1985, that (I) (we) last saw the deceased alive on MARCH 6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Louis A. LANZA MD				DEGREE MD		22c DATE SIGNED 3/6/85	
23a PHYSICIAN'S NAME (TYPE OR PRINT) [Signature]				23b ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205			
23c BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23d DATE 1985 March 9,		23e NAME OF CEMETERY OR CREMATORY Riverview Memorial		23f LOCATION CITY OR TOWN COUNTY STATE Halifax Dauphin Penna.	
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a DATE REC'D. BY REGISTRAR MAR 8 1985		25b REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

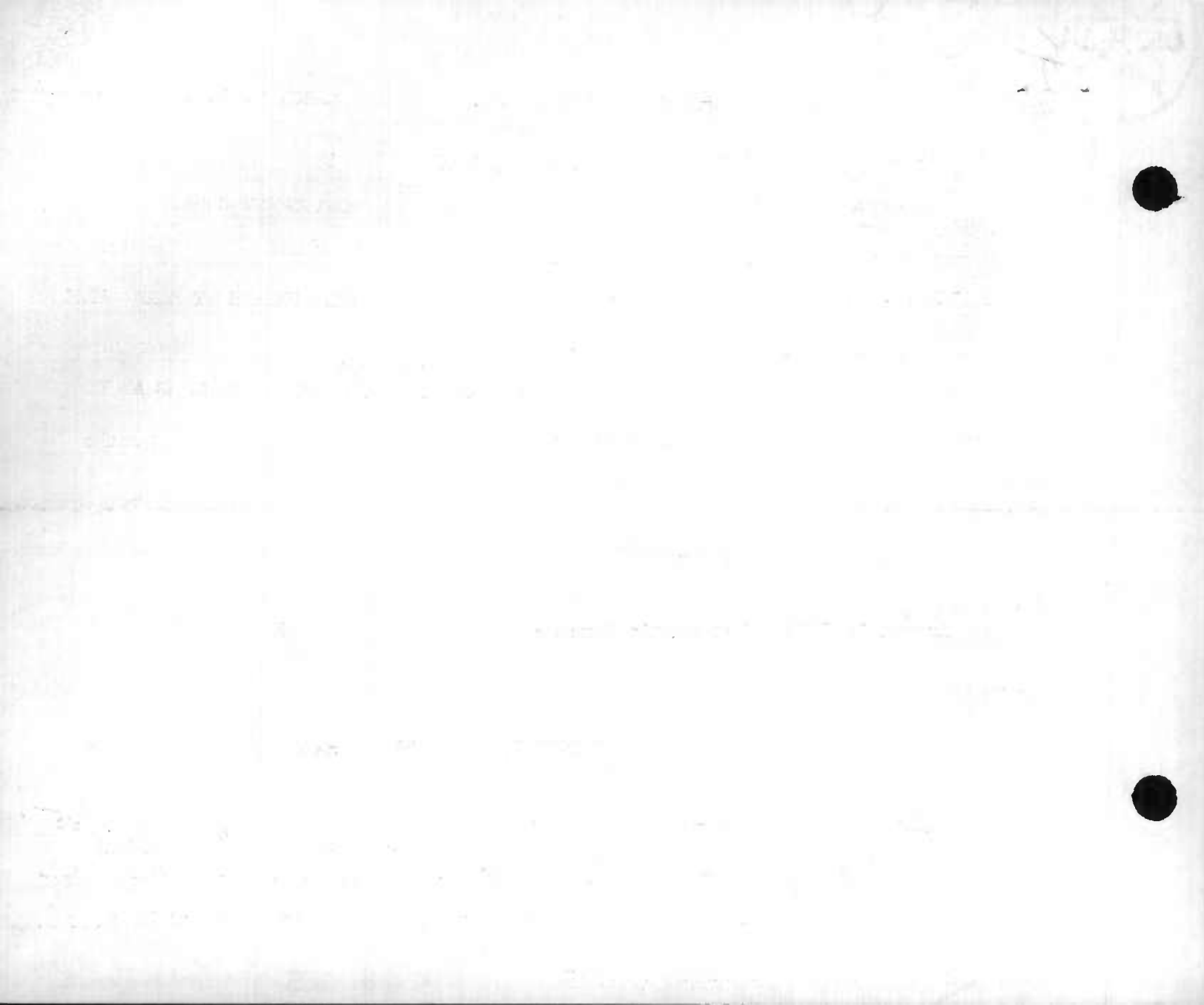
29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial home's permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



098036

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or noted with any injury, or other traumatic event, the medical examiner must be notified by phone.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace P Fuhrman			2a. DATE OF DEATH MONTH DAY YEAR 2 25 85		2b. HOUR 0655 AM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPT. 16 1888	6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	7. UNDER 1 YEAR MONTHS DAYS # UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3806- BONNER ROAD 21216	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE A. FUHRMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGE A. FUHRMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 577-68-5144		17. INFORMANT ADDRESS REV. DR. RICHARD REICHARD - NAT. LUTH. HOME ROCKVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute DIPHtheria Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HRS
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from FEB 24 1985, to FEB 25 1985, that (I) (we) lost saw the deceased alive on FEB 24 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas E. Dooley MD		DEGREE		22c. DATE SIGNED 2-25-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS E. DOOLEY MD		22e. ADDRESS 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB. 28, 1985	23c. NAME OF CEMETERY OR CREMATORY KNIDERS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER, MARYLAND	
24. FUNERAL DIRECTOR NAME HYSONG CO., INC. - 1300-N ST., N.W. WASH., D.C.		25. DATE REC'D. BY REGISTRAR MAR 07 1985			

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FD
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020800

DATE: 10 1964

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

100-100000-100000

100-100000-100000

100-100000-100000

093020

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Aussie L. Gambrell			2a. DATE OF DEATH 3/27/85		2b. HOUR 11:20 PM	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH 1-16-23		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.		
11. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus Driver		
12b. KIND OF BUSINESS OR INDUSTRY School		13a. STREET ADDRESS / ZIP CODE 13306 Georgia Avenue-20906				
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Gambrell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty McClinton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 247-30-9036		17. INFORMANT Edith Gambrell, 13306 Ga Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) Shock						
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CANCER						
DUE TO, OR AS A CONSEQUENCE OF (c) CANCER HEAD AND NECK						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/10, 1984, to 3/27, 1985, that (I) (we) last saw the deceased alive on 3/27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stanley A. Schwartz / MD				22c. DATE SIGNED 3/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley Schwartz MD				22e. ADDRESS 106 Irving St NW: Wash., D.C.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-2-85		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		
23d. LOCATION CITY OR TOWN COUNTY STATE Landover Md.		24. FUNERAL DIRECTOR Marshall's Funeral Home 4217 9th St NW: Washington, D.C.				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

093119

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 5 7

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leo N. Gendron			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1985			2b. HOUR 10:20AM						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 21, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD						
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 705 Mapleton Drive,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Public School			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 705 Mapleton Dr., 20850		
14. FATHER'S NAME FIRST MIDDLE LAST Aldege Gendron				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Pierre								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT ADDRESS Antoinette S. Gendron see # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary ament</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3-19</u> 19 <u>85</u> to <u>3-24</u> 19 <u>85</u> , that (I) (we) (we) saw the deceased alive on <u>3-19</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>D.L. Bucy / SN Jones</u> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3-24-85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.L. Bucy / SN Jones						22e. ADDRESS 809 Veirs Mill Rd Rockville						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Mar. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland												

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work" or "not at home," the medical examiner must be notified at once.

APR 1 1985

1985

John Davidson

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087031

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE C. LAST GENTRY			2a. DATE OF DEATH MONTH 3 DAY 17 YEAR 85		2b. HOUR 10:30 ^{AM}
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH FEB DAY 2 YEAR 1897	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2506 URBANA DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. STREET ADDRESS / ZIP CODE 2506 URBANA DRIVE 20906		
14. FATHER'S NAME FIRST JOSEPH MIDDLE DIVINCENZO LAST	15. MOTHER'S MAIDEN NAME FIRST CECILIA MIDDLE UNKNOWN LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b. SOCIAL SECURITY NO. 215-58-9627		17. INFORMANT LENA BLADEN SAME AS 13 DAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Renal disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks wks yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Osteoporosis</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> 19 <u>80</u> to <u>3/17</u> 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>3/16</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE	22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 3/18/85
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R.T. BENACK MD		22f. ADDRESS 4115 Colie DR. Wheaton, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/20/85	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Jeremiah		F.		Gimlett				03		25		85		5:51A			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
M	W	Jan 19 09		76 YRS.						March 25 1985				5:51A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NEW YORK		U.S.A.				Montgomery											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Olney		Montgomery General Hospital		REPORTER		N.Y. STOCK EXCHANGE											
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Md. Mont.		Olney						17301 Sandy Knolls Dr.									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
PETER		GIMLETT		NORA		ALCOCK											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
YES		WW II		086-09-6765		LILLIAN GIMLETT		SAME AS 13								WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Acute myocardial Dis.		Chronic myocardial Dis.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE													
JOHN S. ROGERS		M.D. Bay		MEDICAL EXAMINER		APR 25 1985											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
1719 SEMINARY RD., SILVER SPRING, MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		3/28/85		CROWNSVILLE VETERANS		CROWNSVILLE ANNE ARUNDEL MD											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
FRANCIS J. COLLINS		APR 1 1985		Julia Davidson-Randall													
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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January 1, 1931

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January 1, 1931

January 1, 1931

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January 1, 1931

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8508860

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) BEATRICE H. GLEASON			2a DATE OF DEATH MONTH 3 DAY 13 YEAR 85			2b HOUR 2:30 AM				
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH January DAY 16 YEAR 1896		6 AGE (IN YEARS LAST BIRTHDAY) 89		7 IF UNDER 1 YEAR MONTHS 89 DAYS 89		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 8914 1st Avenue 20910	
14 FATHER'S NAME FIRST George MIDDLE Haas LAST Haas			15 MOTHER'S MAIDEN NAME FIRST unknown MIDDLE Turley LAST Turley							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 577-34-9825		17 INFORMANT son		ADDRESS 10304 Brunswick Ave. Silver Spring, Md. 20902			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism with coagulopathy		10 days	
DUE TO, OR AS A CONSEQUENCE OF (b) and hemorrhagic bowel infarction		2 days	
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from 2 May 1985 to 13 May 1985 , that (I) (we) saw the deceased alive on 13 May 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Walter E. Goetz MD				DEGREE MD		22c DATE SIGNED 14 May 85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e ADDRESS 2309 SHOREFIELD RD WHEATON MD			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Mar. 16, 1985		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24 FUNERAL DIRECTOR'S NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.				25a DATE REC'D. BY REGISTRAR MAR 18 1985		25b REGISTRAR'S SIGNATURE John F. Collins	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WED 11/11/11

93917 NOTION 1/102

[Faint, mostly illegible handwritten notes on lined paper. Some visible words include "NOTION", "1/102", and "WED 11/11/11".]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) William Edward Gold			2a. DATE KNOWN OF DEATH March 4 1988			2b. DATE OF ESTIMATE March 4 1988		
3. SEX M	4. RACE W	5. DATE OF BIRTH March 17 38	6. AGE (IN YEARS) 45 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD March 4 1988		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Takes Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash Advent Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto
13a. STATE MD		13b. COUNTY Montg		13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Jacob Gold		15. MOTHER'S MAIDEN NAME Paula Greenbaum		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WW II Korea				
16a. SOCIAL SECURITY NO. 221 20 0969		17. INFORMANT Carole Gold same address as #13						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER DATE SIGNED March 4 1988	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 6, 1985	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	23d. LOCATION Adelphi, Maryland	STATE
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24. FUNERAL DIRECTOR'S NAME Pines-Pearson Funeral Homes Falls Church, Va. 22046		25. DATE REC'D. BY REGISTRAR MAR 08 1985		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. *Autopsy findings not available to funeral director.*
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mary Margaret Goldwater				2a. DATE OF DEATH MONTH DAY YEAR 03/ 25/85			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12/ 30/ 11		6. AGE (IN YEARS LAST BIRTHDAY) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Theater	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 20015 5420 Connecticut Avenue N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST S. S. Goldwater		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara AUB		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A			
16a. SOCIAL SECURITY NO. 577-40-6567A		17. INFORMANT (Sister) Janet Daniel		ADDRESS 116 Pinehurst Avenue New York, New York 10033			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-resp. arrest DUE TO, OR AS A CONSEQUENCE OF (b) advanced postencephalic Parkinsonism DUE TO, OR AS A CONSEQUENCE OF (c) terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 25 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 3-16-84 to 3-24-85 , that (I) (we) last saw the deceased alive on 2-23-85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.							
22b. SIGNATURE George F. Sengstack MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-25-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George F. Sengstack MD		22e. ADDRESS 9241 Columbia Blvd, Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1985 March 30,		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, MD				25a. DATE REC'D. BY REGISTRAR APR 8 1985		25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>	

082145

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REC. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louise (N.M.I.) Goodall			2a. DATE OF DEATH MONTH DAY YEAR 3 3 1985		2b. HOUR 10.50 A
3. SEX Female	4. RACE White	5. DATE OF BIRTH 11 TH 12 ^{AY} 1899	6. AGE (IN YEARS LAST BIRTHDAY) 85		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Federal Government		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b. COUNTY N.G.		13c. CITY OR TOWN Greenbelt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2-G Eastway 20770	
14. FATHER'S NAME FIRST MIDDLE LAST Clement Mitch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Ackerman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	16b. SOCIAL SECURITY NO 177-09-2161D	17. INFORMANT (Daughter) Mary Lou Krahe ADDRESS 8917 Ballard Lane Clinton, Maryland 20735			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from about 1975, to 3.3.1985, that (I) (we) last saw the deceased alive on 3.3.1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Rajindra K. Sarin MD		DEGREE MD	22c. DATE SIGNED 3.3.85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJINDRA K. SARIN		22e. ADDRESS 6201 Greenbelt Rd College Park Md 20740	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 7, 1985	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Sharon Mercer Pennsylvania
24. FUNERAL DIRECTOR (NAME) Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		25a. REC'D. BY REGISTRAR 1985	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 6 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harry F. Grant SR.			2a. DATE OF DEATH MONTH DAY YEAR 3/1/85		2b. HOUR 10 p.m.
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3/1/07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service	12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harvey J. Grant			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelaide M. Strobel		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Harry F. Grant Jr. (Son) Same As # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN YEAR 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/28/85</u> 19 to <u>3/1/85</u> 19, that (I) (we) last saw the deceased alive on <u>3/1/85</u> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) last (did not) view the body after death.					
22b. SIGNATURE <u>Henry C. Scruggs MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs MD		22e. ADDRESS 5413 Cedar Hill Bethesda Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 4, 1985	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md.		
24. FUNERAL DIRECTOR NAME DeVol Funeral Home		25a. DATE REC'D. BY REGISTRAR MAR 07 1985		25b. REGISTRAR'S SIGNATURE John Davidson	
25c. ADDRESS 2222 Wisconsin Ave. N.W. Wash					

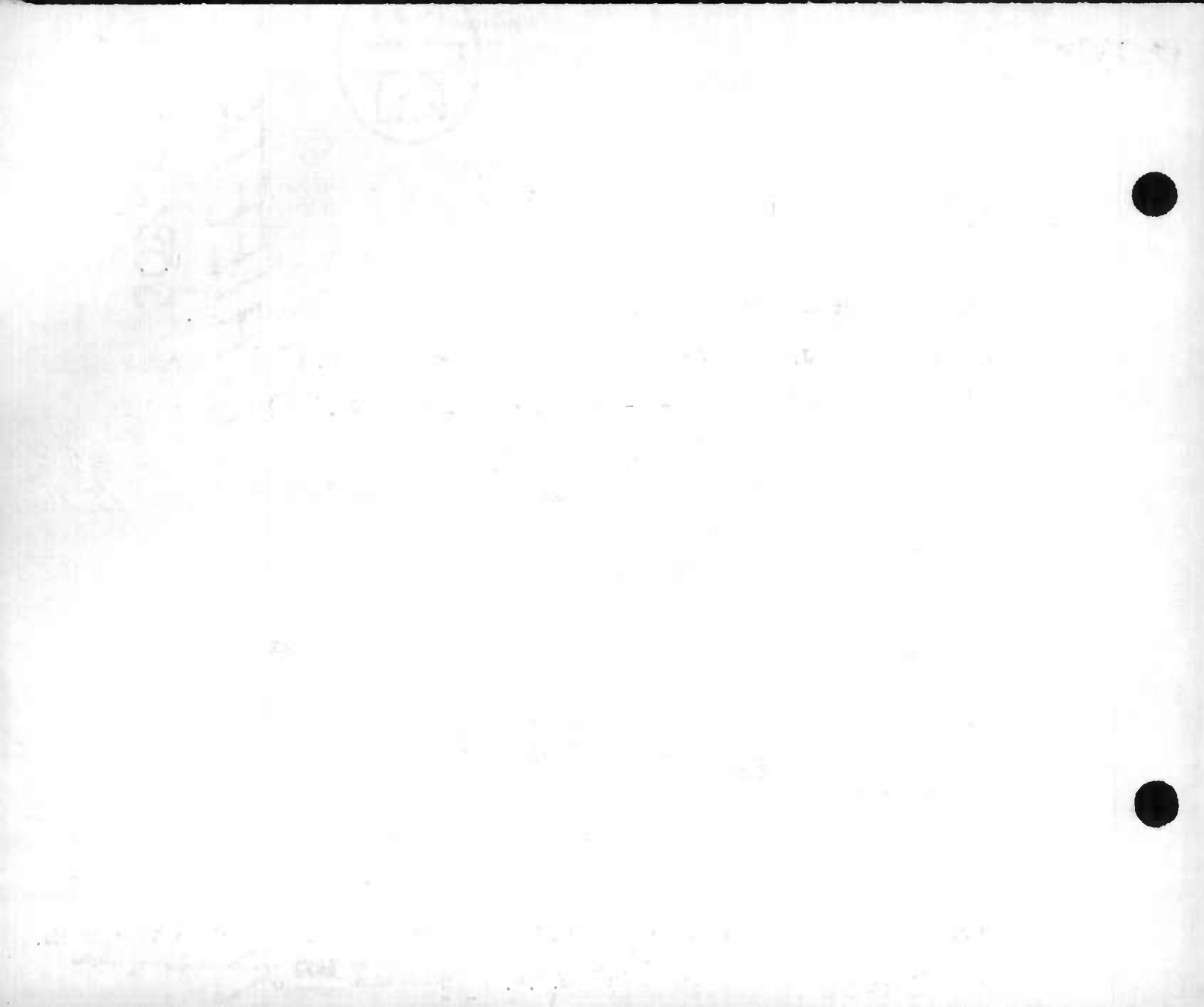
MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, there is any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Julie Greco				2b. HOUR 5:30 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 24, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Potomac		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN-SUCH FACILITY, GIVE STREET ADDRESS) 10042 Carmelita Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY US Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13e. STREET ADDRESS / ZIP CODE 10042 Carmelita Dr./20854	
14. FATHER'S NAME FIRST MIDDLE LAST John Edward Talty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth -- Barrett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 577-60-1481		17. INFORMANT ADDRESS Joseph S. Greco, Same address as #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adverse carcinoma of the colon with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>84</u> , to <u>March 8</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>March 8</u> , 19 <u>85</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Nicholas Rogentine, Jr.</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>March 9, 1985</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>G. NICHOLAS ROGENTINE, JR.</u>				22e. ADDRESS <u>10500 SUMMIT AVE, KENSINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>3/11/85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Brentwood, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 13 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	
5130 Wisconsin Ave, NW, Washington, D.C. 20016							

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BRAND, J. H. 1954

Учредитель: *И.И. Бондарь*.

• 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 2687, 2688, 2689, 2690, 2691, 2692,

150 Wisconsin Ave., Washington, D.C. 20005

098134

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked as injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
DECEASED NAME (TYPE OR PRINT) mae GREEN					DATE OF DEATH MONTH DAY YEAR HOUR 3-24-85 4:55 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 25 89		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spg.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13711 Cresthill Lane 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Garber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 085-30-0134		17. INFORMANT ADDRESS Ms. Helen Newburg - Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HT FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) ASCHD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WKS. 3 WKS. YES									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ORGANIC BRAIN SYNDROME									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/19/85 to 3/24/85 , that (I) (we) lost saw the deceased alive on 3/19/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.									
22b. SIGNATURE Donald R. Lewis		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/24/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS M.D.		22e. ADDRESS OLNEY, MD 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3/24/85		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 28 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JEAN GREENSPAN			2a. DATE OF DEATH MARCH 6 1985		2b. HOUR 11 A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MAY 2, 1912	6. AGE (IN YEARS (LAST BIRTHDAY)) 72 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH EACH YR. GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER	12b. CONTRACTING BUSINESS	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND MONTGOMERY ROCKVILLE			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS 20852 6121 MONTROSE ROAD	
14. FATHER'S NAME HYMAN JACKIER		15. MOTHER'S MAIDEN NAME LENA (UNASCERTAINABLE)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 102-03-5213	17. INFORMANT ADDRESS 7201 GLENBROOK ROAD DR. STANLEY I. GREENSPAN, BETHESDA, MD.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/11/1985 to 3/6/1985, that (I) (we) lost saw the deceased alive on 3/6/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.D. Patel		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL		22e. ADDRESS 6121 MONTROSE RD, ROCKVILLE, MD			

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 3/7/1985	23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDENS, OLNEY, MONTGOMERY, MARYLAND	23d. LOCATION CITY OR TOWN COUNTY STATE
24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C. MAR 11 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "a", it shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



CHIEFMAN/M

30% COTTON



106183

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

8 5 0 8 8 6 8

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EMILY --- GRIBOVSKY		2a. DATE OF DEATH MONTH DAY YEAR 3 6 85		2b. HOUR 4:55 AM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 7 8 05		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MEDICAL DOCTOR	12b. KIND OF BUSINESS OR INDUSTRY MEDICINE
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CORNELIUS GRIBOVSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE POPOVICS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11 167-36-5712		17. INFORMANT ADDRESS THERESA GRIBOVSKY-WIFE SAME AS # 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 84 to 3/6/85 19 85, that (I) (we) last saw the deceased alive on 2/27 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Mark H. EIG		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/6/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. EIG		22e. ADDRESS 9801 GEORGIA AVE. SILVER SPRING		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-11-85	23c. NAME OF CEMETERY OR CREMATORY MD. VETERANS CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM Pr. Geo. MARYLAND				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
500 UNIVERSITY BLVD. WEST SILVER SPRING, MD.				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lillian A Gillespie</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/10/1985</i>			2b. HOUR <i>8:35 PM</i>				
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 16 17</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PENNA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.				
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE & SEAMSTRESS</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>PA</i>			13b. COUNTY <i>SCHUYLKILL</i>		13c. CITY OR TOWN <i>PALE ALTO</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>9999 17901</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>WALTER F. CARL</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MALETO BAUMAN</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>202-10-3110</i>		17. INFORMANT <i>WM. D. GILLESPIE</i>				ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Renal insufficiency*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Night chills multiple myeloma*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

*1.5 years**2 years*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

Chronic Obstructive Pulmonary Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>15 Nov 83</i> to <i>10 Mar 85</i> , that (2) we last saw the deceased alive on <i>10 Mar 85</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)							
22b. SIGNATURE <i>Thomas A. Bensinger</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/11/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas A. Bensinger MD</i>		22e. ADDRESS <i>7525 Greenway Center Drive Greenbelt MD 20770</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>March 14, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woods Luthern Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Port Carbon PENNA</i>	
24. FUNERAL DIRECTOR NAME <i>Jacqueline Walters</i> ADDRESS <i>254 Carroll St</i>		25. DATE REC'D. BY REGISTRAR <i>APR 13 1985</i>		26. REGISTRAR'S SIGNATURE <i>Gail Davidson-Randall</i>			

1860

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

1860

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
THOMAS L.S. GROSS SR.				3 5 85				8:15A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negro		10 14 21		63 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				GUARD					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		P.O. Box 792 Four Corners 20906			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Unknown				Dorothy ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				1WW-II		214-16-7959 Susie K. Gross (wife) same as #13					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u>										TERMINAL	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL ANOXIA</u>										6 WKS	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIAC ARREST</u>										6 WKS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>						STREET					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>85</u> , to <u>3-5</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<u>Leonard L. Deitz</u>								3-7-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
LEONARD L. DEITZ				1900 Forest Glen Dr Silver Spring, Md. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				3-8-85		Md. Nat'l Mem. Pk.		L. Aurel, Pr. Geo, Md.			
24. FUNERAL DIRECTOR				24b. N. Wash. 24c. DATE REC'D. BY REGISTRAR				24d. REGISTRAR'S SIGNATURE			
George R. Snowden				Rockville, Md.				MAR 08 1985 John Davidson-Randall			

1

099174

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Gertie Catherine HALTERMAN			2a. DATE OF DEATH MONTH DAY YEAR March 29, 1985			2b. HOUR 11:35p				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 10, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24650 Halterman Lane				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 24650 Halterman Lane 20879	
14. FATHER'S NAME FIRST MIDDLE LAST Willis Harvey Sirk			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Rebecca Delawter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-74-9643		17. INFORMANT ADDRESS Jesse Daniel Halterman Item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of bile ducts DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>19 85</u> to <u>3/29/85</u> , that (I) (we) lost saw the deceased alive on <u>March 5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Jane A. Frizzell M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/31/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jane A. Frizzell			22e. ADDRESS 300 Park Dr. Frederick Md 21701							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 1, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon		23d. LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.			
24. FUNERAL DIRECTOR Orin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR APR 03 1985				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 7 2

1 - FOR
STATE
REGISTRAR

REG. NO.

094005

1 DECEASED NAME (TYPE OR PRINT) Elizabeth Wise Hamilton			2a. DATE OF DEATH MONTH DAY YEAR March 27, 1985		2b. HOUR 3:27A
3 SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 19, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 6515 40th. Ave. 20782		
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Wise		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Zink			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-38-1738-A		17. INFORMANT ADDRESS Mr. Arthur B. Hamilton Address Same as No# 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Globulostoma multiforme (Brain Tumor) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 12, 1985 to 3/27, 1985 , that (I) (we) last saw the deceased alive on 3/25, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE M. Baig, M.D.				22c. DATE SIGNED 3-27-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Baig, M.D.				22e. ADDRESS 6510 Kenilworth Ave. Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-30-85		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Maryland			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Mike Davidson-Randall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

031007

3:27A

March 27, 1985

Hamilton

Miss

Elizabeth

78

January 10, 1985

White

Female

x

Montgomery

...

...

Education

Teacher

Washington State

...

00783

0210 1001 Ave.

x

Miss

...

...

Miss

...

...

...

Address and no

012-78-1721 Mr. Arthur B. Hamilton No. 172

No

Elizabeth Hamilton

0201 Confrontation Ave. Riverside, California

...

0201 Confrontation Ave. Riverside, California

...

Teacher's name: E. B. Hamilton, Riverside, California

082147

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 7 3

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Miriam M. Hamilton			2a. DATE OF DEATH MONTH DAY YEAR March 3, 1985		2b. HOUR 8:30 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR September 29, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	
14. FATHER'S NAME FIRST MIDDLE LAST Edward - Sawyers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Marie Phillips		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 285-28-2457		17. INFORMANT ADDRESS Marilyn H. Hess (Daughter) Same as # 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Abnormalities DUE TO, OR AS A CONSEQUENCE OF (b) Gastric Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Hip fracture					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Month
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 1984, to March 19 85 that (I) saw the deceased alive on Feb 21 19 85, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death.					
22b. SIGNATURE Patricia D Kellogg MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March/4/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia Kellogg		22e. ADDRESS 809 Viers Mill Rd. Rockville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-5-1985		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland		25a. DATE REC'D. BY REGISTRAR MAR 7 1985			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Silver Spring, Maryland		25b. REGISTRAR'S SIGNATURE He Davidson-Rendall			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

0990337

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD CARLTON HAMILTON			2a. DATE OF DEATH MONTH DAY YEAR MARCH 29 1985		2b. HOUR 5:30 a M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 26 1929		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		
13a. STATE MARYLAND			13b. COUNTY ST. MARY'S		13c. CITY OR TOWN LEXINGTON PK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JOHN HAMILTON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY HARTH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1947-1968		17. INFORMANT ADDRESS LILLIAN M. HAMILTON, 307 WASP ROAD, LEXINGTON				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A R D S/RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from MARCH 4 , 19 85 , to MARCH 29 , 19 85 that (I) (we) lost saw the deceased alive on MARCH 29 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>E. S. Killeavy</i> MC				DEGREE MD		22c. DATE SIGNED 29 MAR 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. S. KILLEAVY, IT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/85		23c. NAME OF CEMETERY OR CREMATORY Immaculate Heart of Mary		23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Park, St. Mary's Md.		
24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.				25. DATE REC'D. BY REGISTRAR APR 3 1985		26. REGISTRAR'S SIGNATURE <i>Davidson</i>		

BP _____

71

100% COAL
DIRECT



COMP X

100% COAL

092133

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCES J HAUSEN			2a. DATE OF DEATH MONTH DAY YEAR 3 27 85			2b. HOUR 4:25 PM	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1 1899		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	
12b. KIND OF BUSINESS OR INDUSTRY Fed. Govt.							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 221 Paula Lynn Drive, 20904							
14. FATHER'S NAME FIRST MIDDLE LAST David Lynch				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) Bonjour			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE NAME OR DATES) N/A				16b. SOCIAL SECURITY NO. 478-18-2873		17. INFORMANT ADDRESS Patricia L. Strosnider-dau-(same 13e)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

ARTERIO SCLEROTIC CARDIO + CORONARY VASCULAR DISEASE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

SENIOR DEMENTIA, RECENT PNEUMONIA

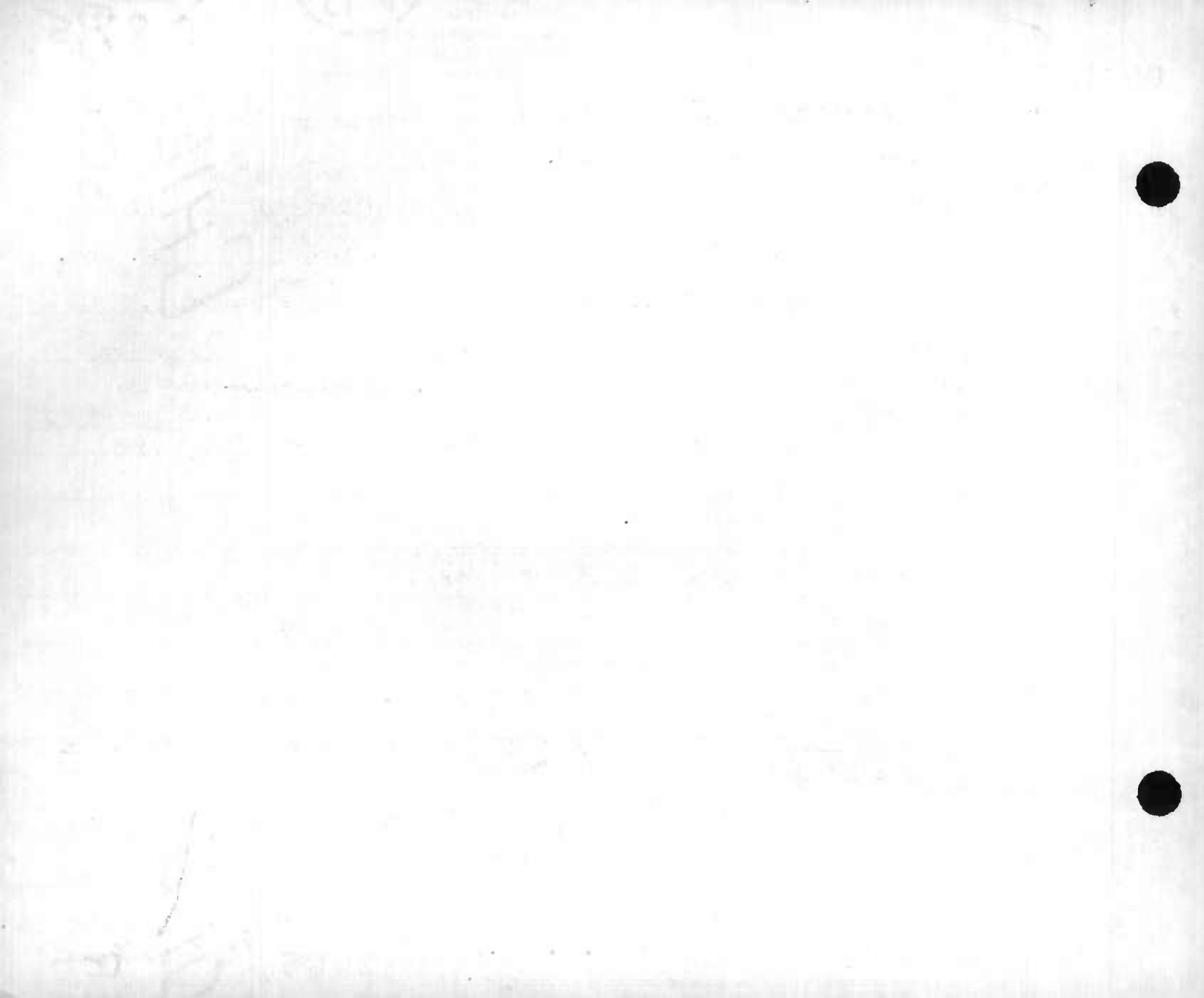
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 1984 to 1985, to 3/27 1985, that (I) (we) saw the deceased alive on 3/25 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dennis R. Schumer				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dennis R. Schumer				22e. ADDRESS 17904 GEORGETOWN AVE #216 OLNEY MD 20832			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-30-1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N. H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 29 1985	
				25b. REGISTRAR'S SIGNATURE Patricia Strosnider			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be certified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Aiton L HARDING			2a. DATE OF DEATH MONTH DAY YEAR 3 11 85			2b. HOUR 2:15 AM	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 24, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Captain		12b. KIND OF BUSINESS OR INDUSTRY County	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Harding		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Moore		13e. STREET ADDRESS / ZIP CODE 19310 Club House Rd. 20879			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 215-46-3431		17. INFORMANT ADDRESS Louise T. Harding, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.H.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM YES YES							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 2/16/85 to 3/11/85, that (1) (we) last saw the deceased alive on 2/16/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (or) (we) (did not) examine the body after death.							
22b. SIGNATURE DONALD R. LEWIS MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS OLNEY, Md 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville, Montg., Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.				25a. DATE REC'D. BY REGISTRAR MAR 14 1985			
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

BP

TO THE HONORABLE SECRETARY OF THE ARMY
WASHINGTON, D. C.
FROM THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of text that are extremely faint and largely illegible due to the quality of the scan. The text appears to be a formal communication or report.]

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the case-hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

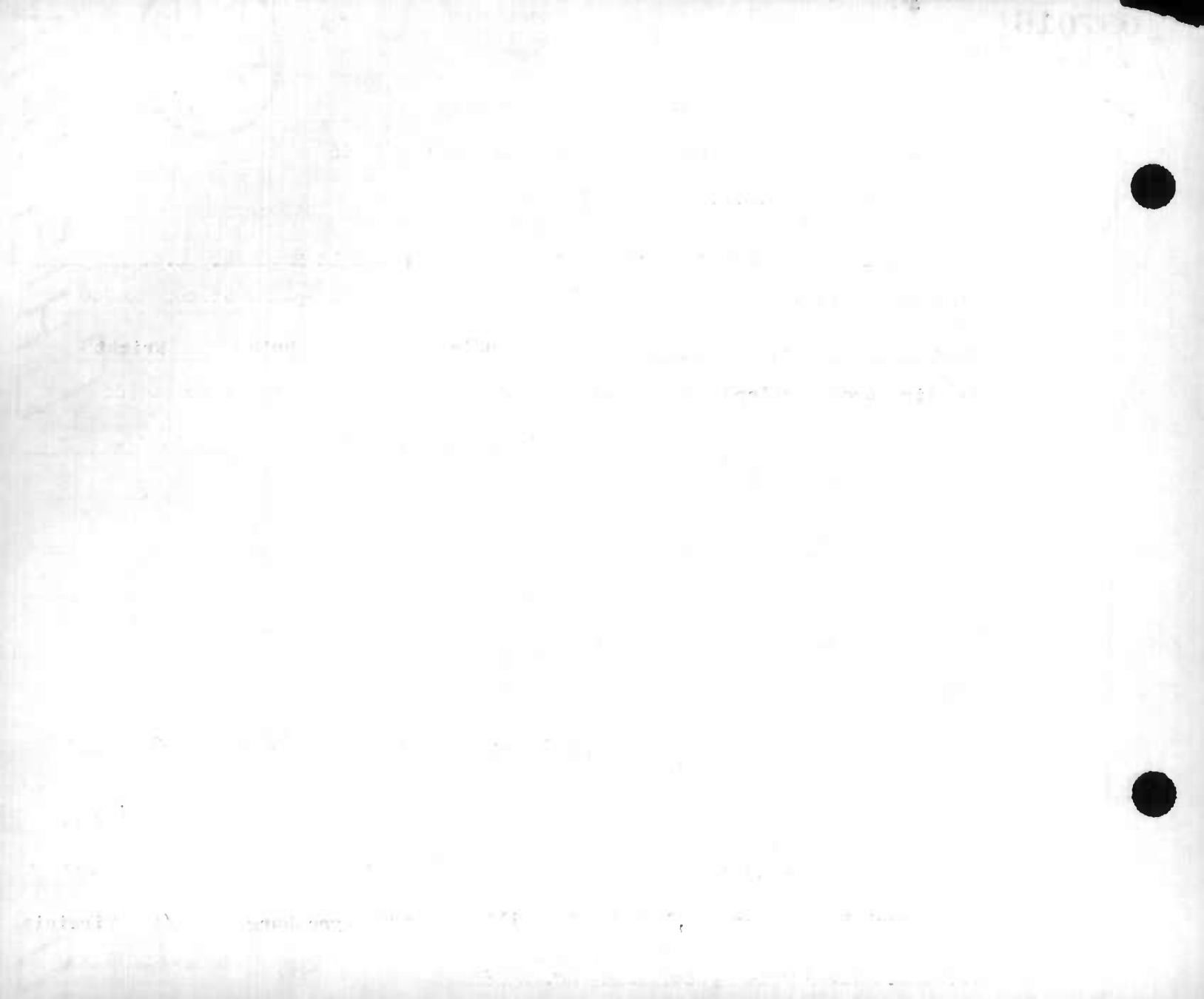
087016

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 7 7

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
John Edward Hathaway		3 16 85		12:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Male	White	08 TH 13 ^{AY} 1918	66	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Washington Adventist Hospital	Flight Engineer	U.S. Airplane		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	P.G.	College Park	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5013 Apache Street 20740	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			
Frederick P. Hathaway	Sudie Ruth Wright	Yes Air Force Retired 228-12-8903			
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
Pauline Hathaway (Wife) Same as 13e		PART 1. DEATH WAS CAUSED BY:			
		IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>			
		DUE TO, OR AS A CONSEQUENCE OF (b) _____			
		DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Mar</u> , 19 <u>85</u> , to <u>16 Mar</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>15 Mar</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Michael Libowitz, MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		<u>16 Mar 85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
<u>Michael Libowitz, MD</u>		<u>11120 New Hampshire Ave 55, Md 20904</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		March 20, 1985		Ft. Hill Memorial Park, Lynchburg	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A.		MAR 22 1985		<u>Julia Davidson-Randall</u>	
4739 Baltimore Avenue Hyattsville, Md. 20781					



099159

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT BRUCE HATT JR		2a. DATE OF DEATH MONTH DAY YEAR 3 30 85		2b. HOUR 3:28pm	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 16 16	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown PENNA		7b. CITIZEN OF WHAT COUNTRY? unknown U.S.A		6. AGE (IN YEARS LAST BIRTHDAY) 68 IF UNDER 1 YEAR (MONTHS) DAYS IF UNDER 24 HRS (HOURS) MIN.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher		12b. KIND OF BUSINESS OR INDUSTRY			

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY P.G. unknown		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7114 Central Ave. 20912	
14. FATHER'S NAME FIRST MIDDLE LAST unknown ROBERT B. HATT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown MARGARET FRIEDHOFF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) unknown YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II 579-50-5136		17. INFORMANT ADDRESS Joan Hatt, 7114 Central Ave., T.P., MD					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Anterior myocardial infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 mins. 120 mins. 150 mins.
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.
none

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 2:30 pm Mar 30, 85 to 3:30 Mar 30, 19 85, that (I) (we) last saw the deceased alive on Mar 30, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>A. Fleming MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/30/85	
--	--	--------	--	--	--	-----------------------------	--

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alexander Fleming, MD		22e. ADDRESS Washington Adventist ED, Takoma Park MD					
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 3, 1985		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi P.D. Md.	
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24. FUNERAL DIRECTOR NAME Takoma Funeral Home		ADDRESS 254 Carroll LN NW		25a. DATE RECD. BY REGISTRAR APR 03 1985		25b. REGISTRAR'S SIGNATURE J. E. Kuntz	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

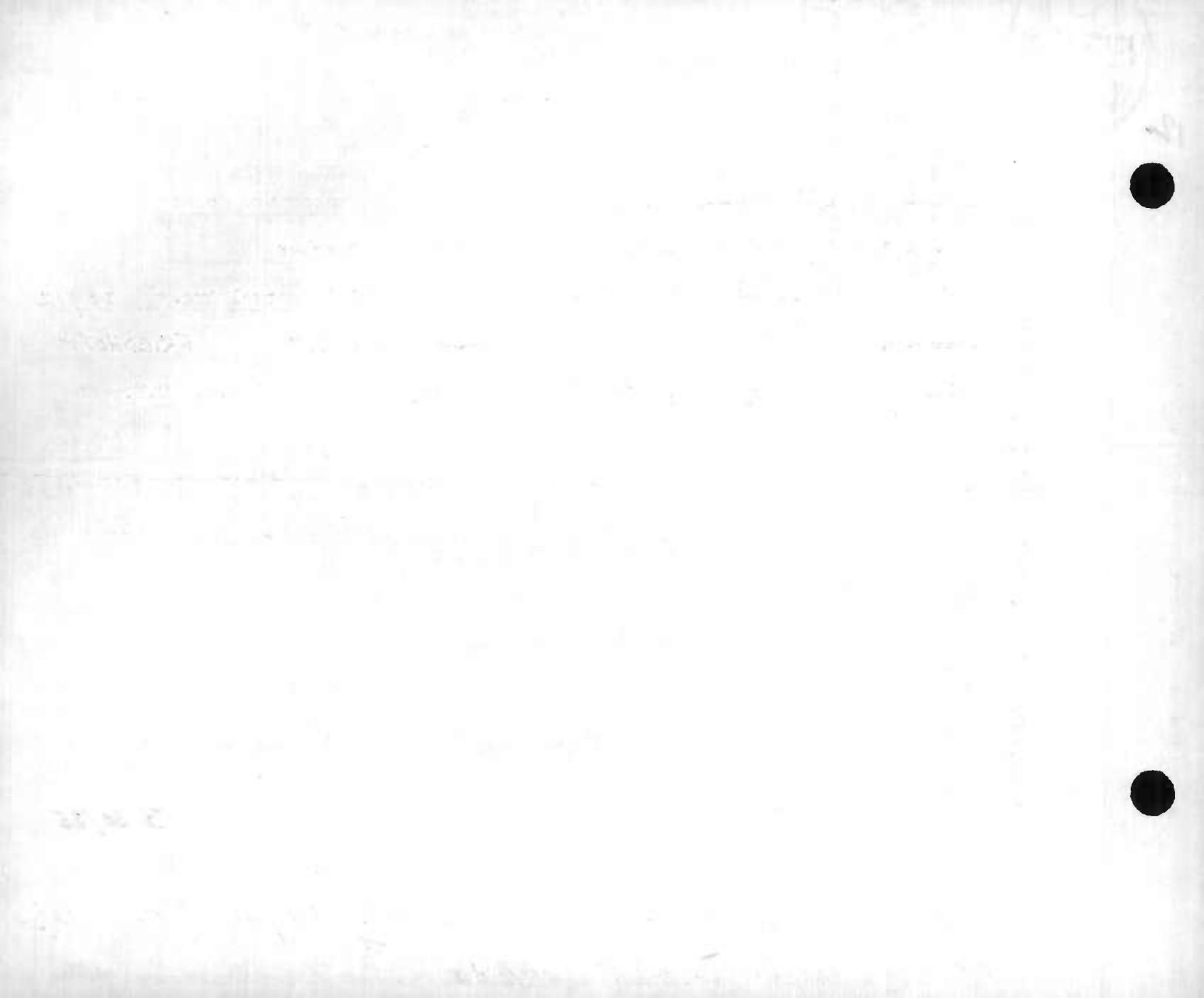
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1, and 2, and be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene for use in the registration to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is checked, the medical examiner must be notified at once.

RELEASED BY DR. JOHN ROGERS, MEDICAL EXAMINER

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

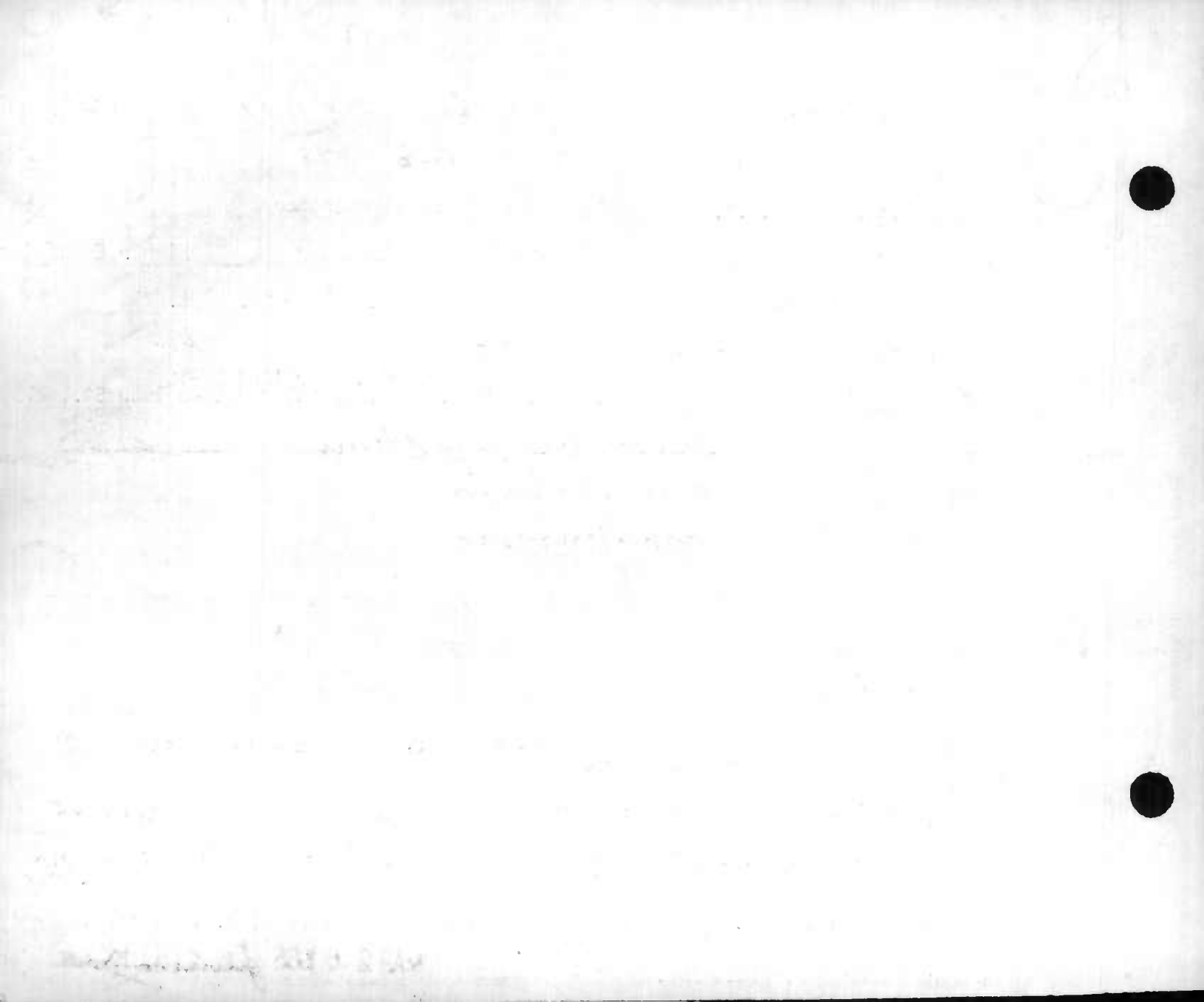
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

091127

1. DECEASED NAME (TYPE OR PRINT) <i>Thomas Pearl Hawkins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3/19/85</i>			2b. HOUR <i>2:00 P M</i>			
3. SEX <i>M</i>		4. RACE <i>B.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12-16-1906</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Educator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Higher Education</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Holbert Hawkins</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ella Dorsey</i>			13e. STREET ADDRESS / ZIP CODE <i>8502 16th St., Apt. 210 20910</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>228-40-3958 A</i>		17. INFORMANT ADDRESS <i>Silver Spring, Maryland 20910</i> <i>Grayce R. Hawkins, wife</i> , <i>8502 16th St., #210,</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Brain Stem infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>2-28-</i> 19 <i>85</i> , to <i>3-19-</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3-18-</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Tony P. Kannarkat MD</i>					DEGREE <i>MD</i>			22c. DATE SIGNED <i>3/19/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>TONY KANNARKAT, MD</i>					22e. ADDRESS <i>8201 16th St. Silver Spring, MD 20910</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Mar. 23, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lincoln Memorial</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, P.G., Maryland</i>		
24. FUNERAL DIRECTOR NAME <i>McGuire Funeral Service, Inc., Washington, DC</i>					25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John D. ...</i>		

BP



082148

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 8 0

1- FOR
STATE
REGISTRAR

REG. NO.

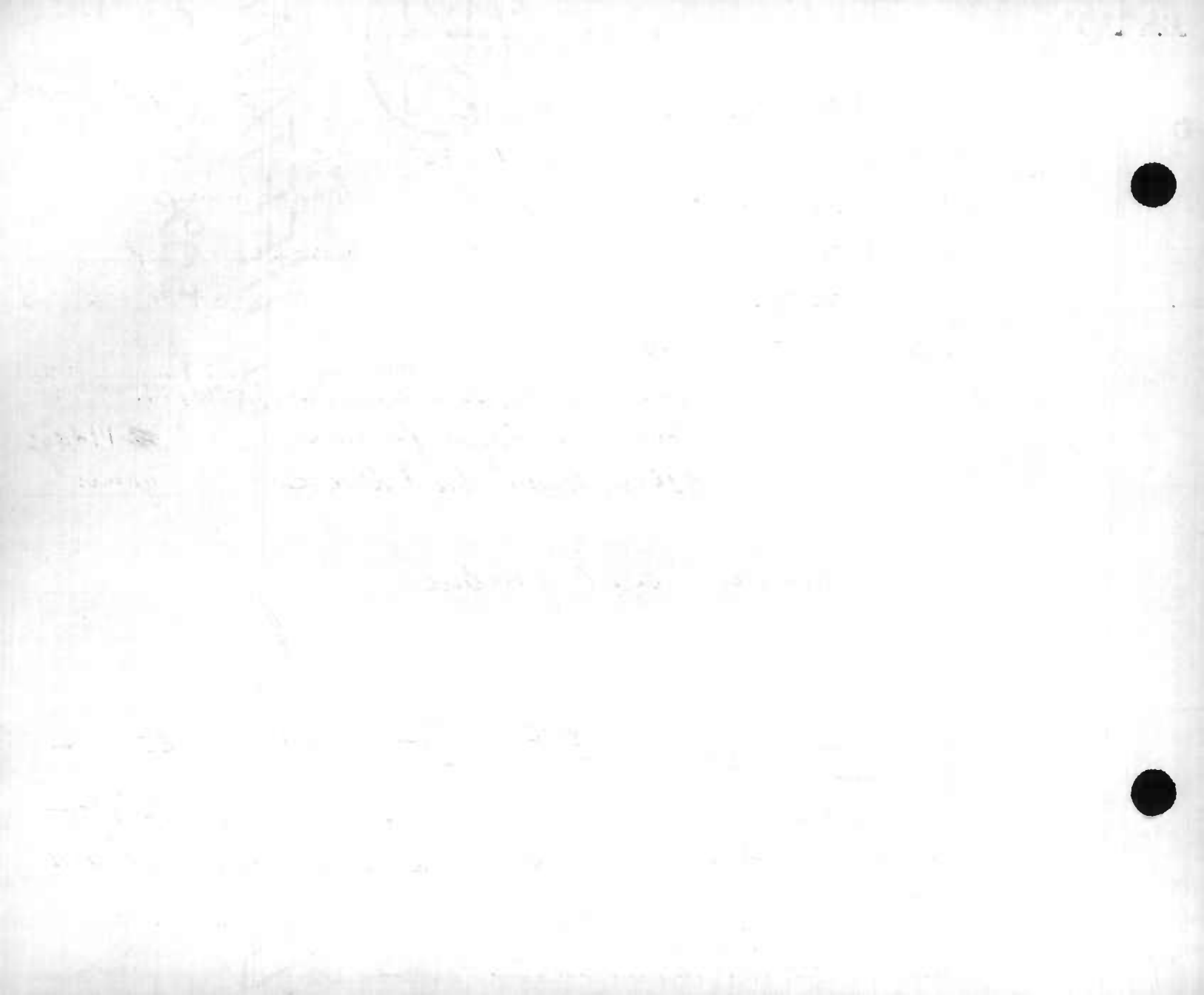
1 DECEASED NAME (TYPE OR PRINT) Florence Catherine Hayre			2a. DATE OF DEATH MONTH DAY YEAR 3 1 85			2b. HOUR 135 AM					
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 1 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1110 Merwood Dr. 20912		
14. FATHER'S NAME FIRST MIDDLE LAST Dennis J. Donovan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hempler			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-48-8060	
17. INFORMANT Son			ADDRESS 1807 Franwall Avenue			17. INFORMANT Alfred J. Hayre, Jr. Wheaton, Md. 20902				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) year										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic renal failure	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from 2/14, 1985, to 3/1, 1985, that (I) (we) last saw the deceased alive on 2/28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Eino Magi, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/1/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EINO MAGI			22e. ADDRESS 4120 New Hampshire Ave., Silver Spring, Md 20904								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Maryland				
24. FUNERAL DIRECTOR NAME Francis J. Collins			ADDRESS 500 University Blvd., W. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Rodale			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hazel Lee L Heaton			2a. DATE OF DEATH MONTH DAY YEAR 03 03 85			2b. HOUR 7:00 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 7 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5008 Allan Road 20816	
14. FATHER'S NAME FIRST MIDDLE LAST Webber Nash				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Dempsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-01-2370		17. INFORMANT ADDRESS Potomac, Md. Joan Schreiber. 9212 Copenhaver Dr.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) malignant hypertension								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Anemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-26-85 to 3-3-85, that (I) (we) lost saw the deceased alive on 3-2-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE HADI BAHAR				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-3-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HADI BAHAR				22e. ADDRESS 8218 Wisconsin Ave. Balt					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial,		23b. DATE 3/6/1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR MAR 08 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

08882

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- STATE REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Norman J. Henderson			2a DATE KNOWN OF DEATH ESTI- MATED 3-9-85			2b HOUR 4:20 PM		
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH MONTH DAY YEAR 3 23 33	6 AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c DATE PRONOUNCED DEAD 3-9-85	7d HOUR 4:20 PM	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		
10 CITY OR TOWN OF DEATH Bethesda		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUDIO		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD			13b COUNTY MONTGOMERY	13c CITY OR TOWN SILVER SPRING	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 903 GIST AVE/20910		
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT - HENDERSON				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABEL C. WESSELS				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1954 TO 1962		17 INFORMANT ADDRESS MARILYN HENDERSON (WIFE) SAME AS #13.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY FAILURE</u> 8809 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>HEAD INJURY</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u> <u>16 HRS</u>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).								
19a. DATE OF OPERATION 3-9-85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? SUBDURAL HEMATOMA					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 1140 P.M. 3 8 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL DOWN FLIGHT OF STAIRS				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY 903 GIST AVE SILVER SPRING MONTGOMERY MD				
22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Francis C. Mayle</i>		TITLE (SPECIFY) M.D. DEPT		MEDICAL EXAMINER		DATE SIGNED 3-9-85		
EXAMINER'S NAME (TYPE OR PRINT) Francis C Mayle		ADDRESS 8200 Wisconsin Ave Bethesda MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MARCH 11, 1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.CO. MARYLAND		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		ADDRESS SILVER SPRING, MARYLAND		25a. DATE RECD. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Raymond			2a. DATE OF DEATH MONTH DAY YEAR March 9 1985			2b. HOUR 5:12 aM			
1. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 7 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 78 3 2		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. 3 2	
3. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Marine Corp		12b. KIND OF BUSINESS OR INDUSTRY Defense	
13a. STATE New York			13b. COUNTY Westchester		13c. CITY OR TOWN Yonkers		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Ernst Ludwig Weichsel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhea Hess			13e. STREET ADDRESS / ZIP CODE 1 David Lane Yonkers, NY 10701			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942- 1971		17. INFORMANT Florette Henri 1 David Lane Yonkers, NY 10701				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 18, 1985 , to March 9, 1985 , that (I) (we) last saw the deceased alive on March 9, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (did) not see the body after death.									
22b. SIGNATURE BH Strand MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. H. Strand, M.D.			22e. ADDRESS Naval Hospital, Navy Medical Command National Capital Region, Bethesda, MD 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 3-10-1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C Md.		
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.			ADDRESS SILVER SPRING, Md.			25a. DATE REC'D BY REGISTRAR MAR 12 1985		25b. REGISTRAR'S SIGNATURE J. Davidson-Randall	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Janet m. Henry</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3/9/85</u>		2b. HOUR pm <u>1:15</u> M	
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>September 16, 1903</u>		
6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS.		7. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.		10. CITY OR TOWN OF DEATH <u>Bethesda</u>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Bethesda</u>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>4400 East-West Highway #401</u>		13f. ZIP CODE <u>20814</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>William Nesbit Marshall</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Jenny Rahlshouse</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No</u> <u>N/A</u>		
16b. SOCIAL SECURITY NO. <u>182-36-7057</u>		17. INFORMANT (Daughter) <u>Janet Drapen, Chevy Chase, Maryland</u>		17b. ADDRESS <u>7410 Oak Lane</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/8/85</u> to <u>3/9/85</u> , that (I) (we) lost <u>saw the deceased alive on above (I) (we) (did) (did not) view the body after death.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated						
22b. SIGNATURE <u>Ralph M. Coan</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>3/9/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RALPH M. COAN</u>		22e. ADDRESS <u>4400 EAST WEST HWY BETHESDA, MD 20814</u>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>March 10, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crem.</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Alexandria Virginia</u>		24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</u>				
25a. DATE REC'D. BY REGISTRAR <u>MAR 13 1985</u>				25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>		

RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Shirley Frances Herman			2a. DATE OF DEATH MONTH DAY YEAR March 25, 1985		2b. HOUR 7:20 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 12, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13251 Venetian Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Weather Bureau		12b. KIND OF BUSINESS OR INDUSTRY US Gov't
13a. STATE Md.			13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walter J. Moxon			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ina F. McCandless		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] None		16b. SOCIAL SECURITY NO. 217 44 2394		17. INFORMANT 9635 River Lake Dr. (Nephew) Kenneth W. Smith Roswell, Georgia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } Chronic Atherosclerosis Severe Rheumatic Heart Dis Immediate yrs					APPROPRIATE INTERVAL BETWEEN POSTMORTEM AND AUTOPSY Immediate
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that this hospital attended the deceased from 3/25/85 to 3/25/85, that (I) (we) last saw the deceased alive on 3/25/85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.					
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Alan I. Kermaier, MD		22b. ADDRESS 10313 Georgia Ave. S.S. Md. 20902		22c. DATE SIGNED 3/25/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/27/85	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hine/Rinaldi 11800 NEW Hampshire Ave. S			25a. DATE REC'D. BY REGISTRAR MAR 26 1985	25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

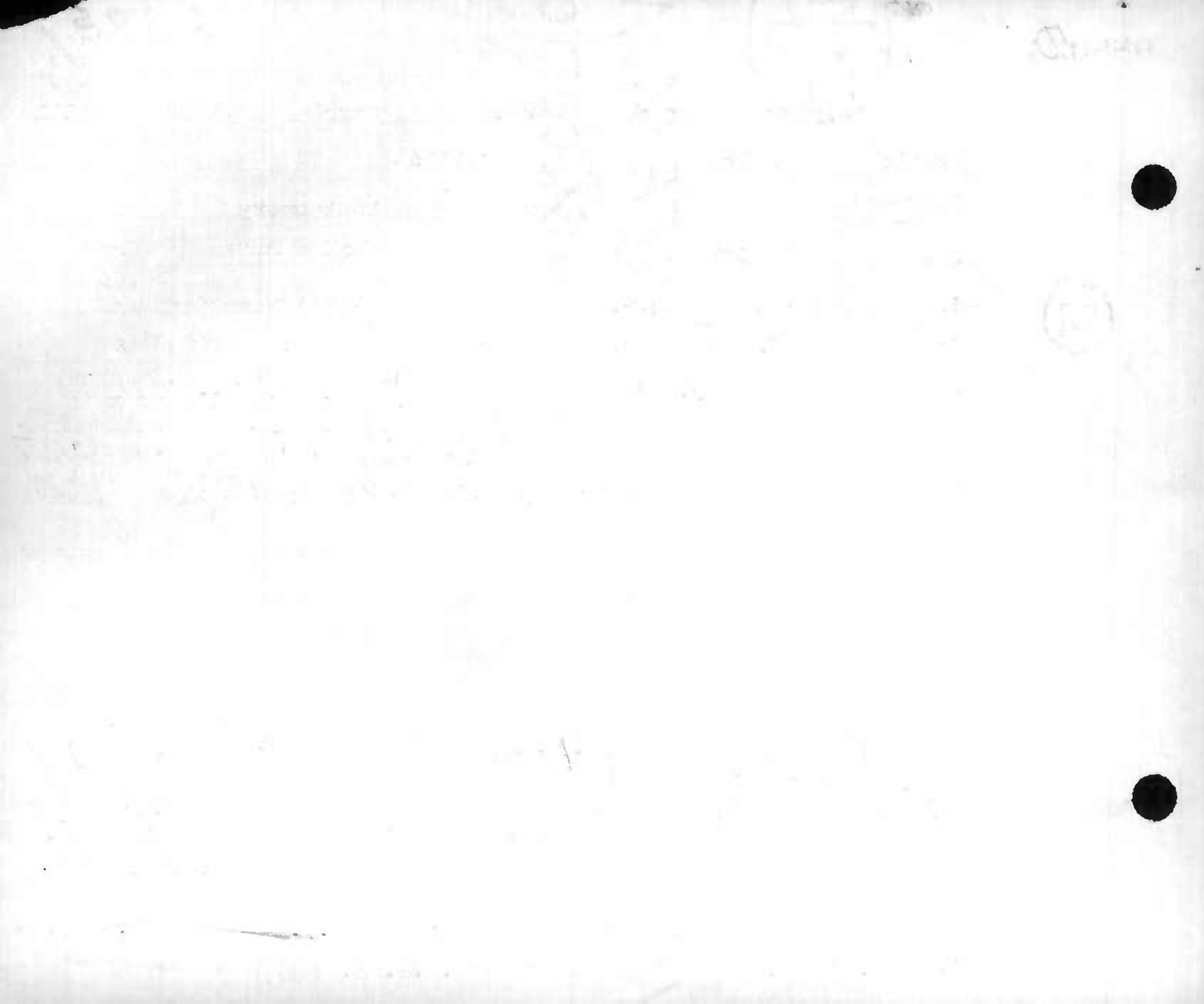
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

098037

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Maurice A. Herndon				3-31-84		4:20 PM			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 13 MRS.	
Male	White	MONTH DAY YEAR 12-29-07		77		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia	USA			Montgomery					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY			
New Carrollton	Holy Cross Emergency Room			Retired-Service Stations					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland	P.G.	N. Carrollton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7403 Longbranch Dr.		28784	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Budd W. Herndon		Grace Horton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		WWII		578-10-5436		Clara Nearey (Daughter)		Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriole sclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of the lung</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
		HOUR A.M. MONTH DAY YEAR P.M. 19		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME STREET FACTORY OFFICE FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3-31-85</u> to <u>3/31-85</u> , that (I) (we) last saw the deceased alive on <u>3-31-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (you) (did) (did not) view the body after death)									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
<u>Richard P. Delaney</u>				5/31/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
RICHARD P. DELANEY, MD		4323 HARVARD ST SIL SPRING MD 20916							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		4/3/85		George Washington		Adelphi PG Md.			
24. FUNERAL DIRECTOR									
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md									
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
APR 2 1985 <u>She Davidson-Randall</u>									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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2/12/2

Proc. of the 12th Int. Conf. on the Physics of Hot Plasmas

1981 S. H. A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR M			
GILBERT POST						HOLT		DATE ESTI- MATED		3		29		19 85		24 HOUR 3:15 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE		WHITE		MAY 7, 1921		63 YRS.		MONTHS		DAYS		HOURS		MIN		3		29 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MICHIGAN		U.S.A.				XX						Montgomery County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Silver Spring		Holy Cross Hospital		INT. ANALYST		D.I.A.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MARYLAND		MONTGOMERY		SILVER SPRING		YES		10212 BIG ROCK ROAD		20901									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
WILLIAM		LESLIE		HOLT		RUTH		POST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
YES		WW II		577-12-5717		BETTE LOU HOLT		SAME AS 13		WIFE									
18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b): DUE TO, OR AS A CONSEQUENCE OF (c):		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
7 8809																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
2		P.M. 3-29- 19 85		Subject fell down steps.															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
home		10212 Big Rock Rd.		Silver Spring		Montgomery													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		Md.															
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		3-30-85													
Ann M. Dixon, M.D.		M.D. Assistant		MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
BURIAL		4/2/85		FT. LINCOLN CEMETERY		BRENTWOOD		PR GEO		MD.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
FRANCIS J. COLLINS		APR 8 1985		[Signature]															
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, READ-
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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QUICK COPY

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8508888					
1. DECEASED NAME (TYPE OR PRINT) Oleta W. Holtz				2a. DATE OF DEATH MONTH DAY YEAR March 7, 1985				2b. HOUR 11:16AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 11, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Florida		13b. COUNTY Indian River		13c. CITY OR TOWN Vero Beach		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1720 46th Avenue 32960	
14. FATHER'S NAME FIRST MIDDLE LAST William Wolfe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Holbert					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-32-4015		17. INFORMANT Son 3400 O Street NW Edgar W. Holtz Washington, DC 20007					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the Lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Renal Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (PERSONAL) attended the deceased from January 85 to March 7, 1985, that (I) (X) saw the deceased alive on March 6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did not) view the body after death.									
22b. SIGNATURE Clifton R. Gruver M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED March 7, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clifton R. Gruver, M.D.				22e. ADDRESS 1145 19th Street, N.W. Washington, D.C. 20036					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 9, 1985		23c. NAME OF CEMETERY OR CREMATORY Ridgellawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Huntington, West Virginia			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAR 13 1985		25b. REGISTRAR'S SIGNATURE John H. ...			

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Film G601 item 16b
 1- STATE 3/29/85 rja
 REGISTRAR

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edwin Carroll Hornbarger			2a. DATE OF DEATH MONTH DAY YEAR March, 16 1985		2b. HOUR 9:35 p.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec., 20 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4501 Bayne Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Carpenter	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4501 Bayne Street 20853
14. FATHER'S NAME FIRST MIDDLE LAST Edger Daniel Hornbarger			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Beulah Fitzgerald		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY # (IF YES, GIVE YEAR OF DATES) WW II/Korea 228-12-2072		17. INFORMANT ADDRESS Evelyn B. Hornbarger Same as items 13a-e	
18. CAUSE OF DEATH Enter only one cause probable for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the undersigned) attended the deceased from 3/15/85 to 3/16/85 that the deceased died on 3/16/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE Hermon C. Maranzini, M.D.		22c. DEGREE M.D.		22d. DATE SIGNED 3/18/85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Hermon C. Maranzini, M.D.		22f. ADDRESS 50 W. Edmonston Drive Rockville, Maryland 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/20/85	23c. NAME OF CEMETERY OR CREMATORY Highland Memorial Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Dublin, Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852			25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE W. W. W. W. W.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
Dana Mae Howard		Female		Black		7 11 16	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Tennessee		USA				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Arthur T. Henley		Nona Dobson		No		412-15-0399	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Ruth Joseph		Same as #13c		Acute Respiratory Failure		1 hr	
				Chronic Obstructive Lung Disease		5 yrs	
				Bronchiectasis		10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
Tricuspid Insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 11/28 1983 to 3/6 1985, that (I) (we) lost saw the deceased alive on 11/6 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE OF PHYSICIAN Alfred Munzer M.D.		22c. DATE SIGNED 3/6/85		22d. ADDRESS 7600 Carroll Avenue Takoma Park Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/10/85		Craig's Chapel Cem.		Greenback Loudon, Tennessee	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis J. Collins		MAR 11 1985		Davidson-Randall			
500 University Blvd. w Silver Spring, MD 20901							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having been any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

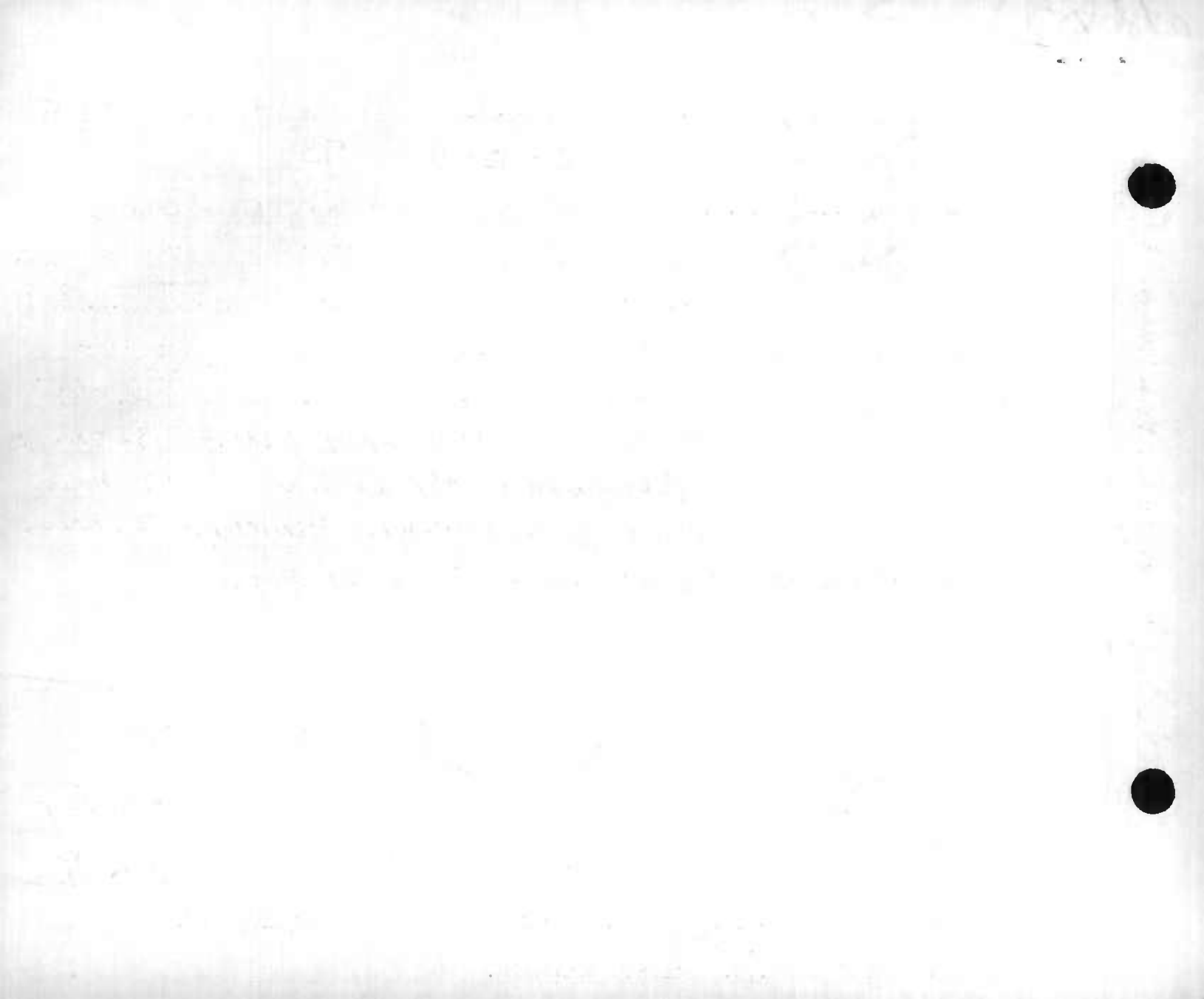
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary A. Howard			2a. DATE OF DEATH MONTH DAY YEAR Mar 14, 1985		2b. HOUR 4:32 AM	
3. SEX female		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 5-10-11		
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Washington, DC		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Vincent F. Howard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary A. Dasenbrock				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-60-6802		17. INFORMANT Paul T. Howard		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE GASTRO-ESOPHAGEAL HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-5 MINUTES 24 Hours 24 Hours				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: METASTATIC BREAST CARCINOMA - DIABETES MELLITUS						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/14/85 to 3/14/85, that (I) (we) last saw the deceased alive on 3/14/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE Laurence D. Marcus M.D.				22c. DATE SIGNED 3/14/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAURENCE D. MARCUS, M.D.				22e. ADDRESS 10313 GEORGIA AVENUE, SILVER SPRING, MD. 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		
24. FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE MAR 18 1985		
500 University Blvd., W. Silver Spring, Md.						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.



093058

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 8 9 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Samuel L Humes</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3. 21 85</u>		2b. HOUR M <u>6-15 P</u>
3. SEX <u>M.</u>	4. RACE <u>B</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>5. 13 1900</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>	7b. CITIZEN OF WHAT COUNTRY? <u>US</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONT</u> MD.	
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Service Employee</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>1705 East West Highway 20901</u>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>Lewis Humes</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Willie Stewart</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>719-10-6946</u>		17. INFORMANT <u>Washington, D. C. 20011</u> <u>Samuel L. Humes, Jr., son, 5128 12th St. NE.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-31-84</u> , 19 <u>84</u> , to <u>3-21-85</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3-21-85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Philip W. Roth, MD</u>		DEGREE		22c. DATE SIGNED <u>3-22-85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Philip W. Roth, MD</u>		22e. ADDRESS <u>Suite 32, 831 University Blvd. East Silver Spring, MD 20903</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Mar. 25, 1985</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Highland Park, Maryland</u>
24. FUNERAL DIRECTOR NAME <u>McGuire Funeral Service, Inc., Washington, DC</u>		7400 Georgia Ave. NW		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>MAR 27 1985</u>	

BP _____
DHMH - 16 60M 7/84
(VRA 15.4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JoAnn Marie Hunt			2a. DATE OF DEATH MONTH DAY YEAR March 13 '85		2b. HOUR A. M. 10:30
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 7 1926		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
11. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 421 Christopher Ave. #14		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY -
13a. STATE Md.			13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST George John Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Isabella Christinsen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 472-22-5392		17. INFORMANT ADDRESS 421 Christopher Ave. #14 Gerald R. Hunt Gaithersburg, Md. 20879	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian Cancer Stage III</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Rheumatic Heart Disease</u>					
19a. DATE OF OPERATION 10-19-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ovarian cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct</u> 19 <u>84</u> to <u>Mar</u> 19 <u>85</u> , that (I) lost saw the deceased alive on <u>Mar 12</u> 19 <u>85</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did <u>did not</u> view the body after death. <u>March 13 1985 10:30 AM</u>					
22b. SIGNATURE <u>Jennifer M. Olson MD</u>		22c. DATE SIGNED 3/13/85		22d. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Jennifer M Olson		22f. ADDRESS 501 N Frederick Ave Gaithersburg Md 20879			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/16/85	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24. FUNERAL DIRECTOR NAME <u>Gartner Sandison 316 E. Diamond Ave.,</u>		25. DATE RECD. BY REGISTRAR MAR 20 1985		26. REGISTRAR'S SIGNATURE <u>Jennifer M. Olson</u>	
Gartner Sandison F.H. Gaithersburg, Md. 20877					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Schley R. Hunt										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 6 YEAR 85	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 1988	6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	2c. DATE PRONOUNCED DEAD MONTH 3 DAY 6 YEAR 1985		2b. HOUR 1248 P M P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Tool & Die Maker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST Thomas MIDDLE Kelsey LAST Hunt		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Smith LAST Smith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW I		16b. SOCIAL SECURITY NO. 273-10-9929		17. INFORMANT ADDRESS Robert R. Hunt same as 13c					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cerebral arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Tauber		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 3-6-85 Bethesda Md.					
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		ADDRESS 8218 Wisconsin Ave									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/9/85		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN Bedford, Ohio COUNTY STATE					
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

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094016

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY L HYNSON			2a. DATE OF DEATH MONTH DAY YEAR 3 28 85		2b. HOUR 5.05A.M.						
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 16 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 72 HRS HOURS MIN. 0 0	
9a. BIRTHPLACE (COUNTRY) OREGON		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 211 EAST HAMILTON AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN ENGIN		12b. KIND OF BUSINESS OR INDUSTRY POWER SYSTEMS			
13a. STATE MARYLAND						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GARRETT L. HYNSON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SIBEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 207-05-6268		17. INFORMANT ADDRESS RUTH W. HYNSON SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) Polycystic Renal & Liver Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Aortic stenosis, Coronary Artery Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART 1 OR PART 2)							
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 1979 , to 3 28 85 , that (I) (we) last saw the deceased alive on 3 27 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Rajindra K. Sarin		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3 28 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJINDRA K. SARIN				22e. ADDRESS 6201 Greenbelt Road College Pk Md 20740							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/30/85		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MARYLAND 20901		25a. DATE REC'D. BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERTHA		MIDDLE OPHELIA		LAST JACK		20. DATE OF DEATH MONTH 03 DAY 21 YEAR 85		26. HOUR 1:46 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH Sept. 13 DAY YEAR 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TELEPHONE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. MD.		13b. COUNTY HOWARD		13c. CITY OR TOWN BROOKEVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4590 Rt. #97 20833	
14. FATHER'S NAME FIRST EDWARD MIDDLE W. LAST GAYLOR					15. MOTHER'S MAIDEN NAME FIRST PEARL MIDDLE M. LAST ZIMBRO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-18-0115		17. INFORMANT ROBERTA SIRON		ADDRESS 4586 Rt. #97 MD. 20833			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.U.D.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM YRS YES	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/23 19 84 , to 3/21 19 85 , that (I) (we) lost saw the deceased alive on 3/1 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									
23a. SIGNATURE Donald R. Lewis MD DEGREE MD						23b. DATE SIGNED 3/21/85			
23c. PHYSICIAN'S NAME (TYPE OR PRINT) DR. DONALD R. LEWIS				23d. ADDRESS OLNEY, MD. 20832					
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23f. DATE March 23, 1985		23g. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23h. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD P. GEORGE MD.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879						25a. DATE REC'D. BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE Donald R. Lewis	

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) IOLA V. JACKSON			2a. DATE OF DEATH MONTH 3 DAY 29 YEAR 85			2b. HOUR 6:10 M					
3 SEX F		4 RACE B		5. DATE OF BIRTH MONTH 6 DAY 27 YEAR 29		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0	
7a BIRTHPLACE COUNTRY MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY			12b KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD.			13b COUNTY MONT.		13c CITY OR TOWN ROCKVILLE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 13113 SUPERIOR ST. 20873		
14 FATHER'S NAME FIRST LEON MIDDLE WASHINGTON LAST BEATRICE				15. MOTHER'S MAIDEN NAME FIRST BEATRICE MIDDLE DORSEY LAST DORSEY							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 215-38-3313		17 INFORMANT'S ADDRESS William E. JACKSON - HIS - SAME #13						
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic colon cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 7/84, 2/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colon CA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____						
22a. I certify that (1) (this hospital) attended the deceased from 3 19 84 to 3/27 19 85 , that (1) (we) last saw the deceased alive on 3/21 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Peter Sherer					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/3/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD					22e. ADDRESS 3947 Ferrara Dr Wheaton MD 20906						
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL			23b. DATE 4-4-85		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN MEM. PARK			23d. LOCATION CITY OR TOWN Rockville COUNTY MONTGO. STATE MD.			
24. FUNERAL DIRECTOR NAME GEORGE R. SNOWDEN					24b. ADDRESS 246 N. Wash. St. ROCKVILLE, MD.			25a. DATE REC'D. BY REGISTRAR APR 03 1985			
					25b. REGISTRAR'S SIGNATURE [Signature]						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Medical Registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



094148

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WELDON BERNARD JAMES			2a. DATE OF DEATH MONTH DAY YEAR MARCH 14 1985		2b. HOUR 11:06^{PM}
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 14 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA		13b. COUNTY N/A	13c. CITY OR TOWN ALEXANDRIA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 700 S. VIEW TERRACE 22314
14. FATHER'S NAME FIRST MIDDLE LAST LUCIAN ADWELL JAMES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA WELDON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1972		17. INFORMANT ADDRESS MARGARET JAMES, 700 S. VIEW TERRACE, ALEXANDRIA, VA 22314	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from FEBRUARY 26 , 19 85 , to MARCH 14 , 19 85 , that (we) last saw the deceased alive on MARCH 14 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>William A. Delacey</i>		DEGREE MD		22c. DATE SIGNED 15 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. A. DELACEY, LT. MC. USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 15 Mar 85	23c. NAME OF CEMETERY OR CREMATORY Uniformed Services University of the Health Sciences		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda, Maryland	
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		25a. DATE REC'D. BY REGISTRAR MAR 26 1985			
		25b. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
GENE BUTTON JEFFREY				MARCH 1 1985		5:59 a.m.	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE	CAUCASIAN	SEPTEMBER 14 1907		77 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
ARKANSAS	UNITED STATES			MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NAVAL HOSPITAL		RETIRED		U.S.M.C.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE	
13a STATE 13b COUNTY		TRIANGLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		18049 JOPLIN ROAD 22172	
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
WILBUR B. JEFFREY		ETTA MAE SANDEFEUR					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		1925-1954		DEBBIE JEFFREY, 18049 JOPLIN ROAD, TRIANGLE, VA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>PROSTATE ADENOCARCINOMA</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 22 1985</u> , to <u>MARCH 1 1985</u> , that (I) (we) last saw the deceased alive on <u>MARCH 1 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		DEGREE		22c DATE SIGNED			
<i>William A. Delacey</i>		MD		1 MAR 85			
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		22f REGISTER'S SIGNATURE			
W. A. DELACEY, LT, MC, USNR		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE	
Burial		Mar. 4, 1985		Quantico National		Triangle, Virginia	
24 FUNERAL DIRECTOR NAME		24b ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Cunningham-Mountcastle Funeral Home		13318 Occoquan Rd. Woodbridge, VA 22191		MAR 5 1985		<i>[Signature]</i>	

84 15 20



per me

098038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST SIDNEY		MIDDLE E		LAST JOHNSON		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 03 30 1985		2b. HOUR 6:12 P.M.	
3. SEX M	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 08 28 09		6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		IF UNDER 1 YR. MONTHS DAYS 7 2		IF UNDER 24 HRS. HOURS MIN. 19		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 03 30 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE District of Columbia						13b. CITY OR TOWN Washington		13c. STREET ADDRESS 1103 Bellevue Street, S.E.			
14. FATHER'S NAME FIRST MIDDLE LAST Lawson Johnson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie J. Tate					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578 09 1655		17. INFORMANT ADDRESS Elsie B. Marshall-daughter-1103 Bellevue Street, S.E., Wash., D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John Tauber</u>				M.D. <u>Deputy</u>				MEDICAL EXAMINER <u>Bethesda Md.</u>			
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tauber</u>				ADDRESS <u>8218 Wisconsin Ave</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April 4, 1985		23c. NAME OF CEMETERY OR CREMATORY Maryland National Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Md	
24. FUNERAL DIRECTOR NAME <u>John I. Stewart</u>				25a. DATE REC'D BY REGISTRAR APR 2 1985				25b. REGISTRAR'S SIGNATURE <u>John I. Stewart</u>			
Stewart Funeral Home-4001 Benning Road N.E.											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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BP

DNH-147
(NR A15 ME (S))

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RIGHT MOTION 2003

CHIEFLAIN BOND



087095

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 0 1

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William W. Johnson</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>MARCH 17, 1985</i>		2b. HOUR <i>1:20 P.M.</i>
3. SEX <i>Male</i>	4. RACE <i>CAUCASIAN</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11-13-03</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (WORK OR BUSINESS OR RETIRE) <i>ASST. TREASURER</i>	12b. KIND OF BUSINESS OR INSTITUTE <i>SMITHSONIAN INSTITUTE</i>	
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>MONTGOMERY</i>	13c. CITY OR TOWN <i>SILVER SPRING</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS / ZIP CODE <i>605 DARTMOUTH AVENUE 20910</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>BEAUREGARD S. JOHNSON</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SARAH HALL</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-46-0081</i>		17. INFORMANT WIFE <i>GERTRUDE E. JOHNSON</i> ADDRESS <i>3511 GREENLY STREET SILVER SPRING, MD. 20901</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumoniae meningitis infection</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Stroke</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) did not attended the deceased from <i>3-17-85</i> to <i>3-17</i> , 19 <i>85</i> , that (I) did not saw the deceased alive on <i>3-17</i> , 19 <i>85</i> , and that in my own opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death.					
22b. SIGNATURE <i>Seruch T. Kimbell MD</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3-17-85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SERUCH T. KIMBELL</i>		22e. ADDRESS <i>9801 Virginia Ave. Silver Spring, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>BURIAL</i>		23b. DATE <i>3/21/85</i>	23c. NAME OF CEMETERY OR CREMATORY <i>UNION CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY <i>LEESBURG VIRGINIA</i>
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 22 1985</i>		25b. REGISTRAR'S SIGNATURE <i>a Davidson-Randall</i>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for an autopsy.

087032



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 0 2

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Elizabeth B. Johnston			2a. DATE OF DEATH MONTH DAY YEAR 03 27 85			2b. HOUR 5:05AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 25, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medical Sec.	
12b. KIND OF BUSINESS OR INDUSTRY Hospital		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Sandy Spring	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17340 Quaker Lane 20860					
14. FATHER'S NAME Gus Beyer				15. MOTHER'S MAIDEN NAME Inez Hannah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 487-12-3792		17. INFORMANT Robert B. Webber			
				4412 Flower Valley Dr. Rockville, Md. 20853			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Branchopneumonia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days

DUE TO, OR AS A CONSEQUENCE OF

(b) Aspiration of secretions

2 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Lymphoma involving stomach and spleen

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 26, 19 85, to March 27, 19 85, that (I) (we) lost saw the deceased alive on March 27, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.							
22b. SIGNATURE Joan R. Kumar		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED March 27, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joan R. Kumar		22e. ADDRESS Montgomery Gen'l Hosp., Olney MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MARCH 28, 1985		23c. NAME OF CEMETERY OR CREMATORY Balt. Wash. Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P. George Md.	
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR MAR 29 1985		25b. REGISTRAR'S SIGNATURE J. Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

09212



Exhibit received from [illegible]

March 11, 1952

(5100)

Mr. [illegible]

Department of [illegible]

074102

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 0 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Michael W. Josey</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3-7-85</u>			2b. HOUR <u>606p</u> M			
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>May 27, 1954</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>30</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Georgia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> County MD			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Model</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Fashion</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Fairfax</u> 13b. CITY OR TOWN <u>Burke</u> 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13d. STREET ADDRESS / ZIP CODE <u>10310 Bridgetown Point</u>		13e. STREET ADDRESS / ZIP CODE <u>22015</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Windom E. Josey</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Barbara Howell</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>Not Available</u>		17. INFORMANT NAME ADDRESS <u>Father Windom E. Josey Rt 1 B1155 Ridgeland, SC 29936</u>					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Unknown central nervous system infectionAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH4 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Acquired Immunity Syndrome6 mos

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (I) (this hospital) attended the deceased from <u>3/1/85</u> to <u>3/7/85</u> , that (I) (we) last saw the deceased alive on <u>3/1/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <u>Dr. Fred A. Gill, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/8/85</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Fred A. Gill, M.D.</u>				22d. ADDRESS <u>4773 Broadly Blvd Chy, chas dld 20815</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>March 11, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bonaventure Cemetery Savannah, Georgia</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 13 1985</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be distributed for use at the burial or cremation. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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July 15

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July 15

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Gertrude Justh			2a. DATE OF DEATH MONTH DAY YEAR 3 8 85			2b. HOUR 10:15p			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.		10. CITY OR TOWN OF DEATH Rockville	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home for the aged		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) store clerk		12b. KIND OF BUSINESS OR INDUSTRY unknown		13a. STREET ADDRESS / ZIP CODE 600 Light Street 21230		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Wildman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Vogel		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-01-4022		17. INFORMANT ADDRESS Rev. Richard Reichard-9701 Veirs Dr. Rockville, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **C.V.A.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
18 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>March 1</u> , 19 <u>85</u> to <u>March 8</u> , 19 <u>85</u> , that (I) <u>met</u> last saw the deceased alive on <u>March 1</u> , 19 <u>85</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated signature (I) <u>did not</u> view the body after death.							
22b. SIGNATURE Thomas E. Dooley, M.D.		DEGREE M.D.		22c. DATE SIGNED MARCH 9, 1985		22d. ADDRESS 17904 BELVIDERE AVENUE OLNEY, MARYLAND 20822	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 14, 1985		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Hysong Co. Inc. 1300 N. St. N.W. Washington, D.C.				25a. DATE REC'D. BY REGISTRAR MAR 18 1985			
25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

BP

100-1024

APR 23 1902

~~Warrant~~

Warrant for the arrest of

James Earl Ray

born [illegible]

at [illegible]

573

x

James Earl Ray

MAR 18 1902

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8905

1- FOR STATE REGISTRAR

093026

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE F. LAST KAMENAR

2a. DATE OF DEATH MONTH DAY YEAR MARCH 25, 1985 2b. HOUR 5:35 AM

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR May 14, 1924

6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH BETHESDA 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife 12b. KIND OF BUSINESS OR INDUSTRY home

13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 12008 St. Dunston Lane 20906

14. FATHER'S NAME FIRST MIDDLE LAST Joseph F. Taylor 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Collins

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 579-20-6793 17. INFORMANT ADDRESS Edward M. Kamenar same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure, caused by
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Larynx
DUE TO, OR AS A CONSEQUENCE OF (c) Cachexia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☒ NO ☐ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21a. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-19 19 85 to 3-25 19 85, that (I) (we) last saw the deceased alive on 3-24 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)

22b. SIGNATURE Robert T. Thibadeau DEGREE 22c. DATE SIGNED 3/25/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU 22e. ADDRESS Rockville, Md 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 3/28/86 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery 23d. LOCATION CITY OR TOWN Silver Spring, Maryland

24. FUNERAL DIRECTOR Tuson Wheeler Funeral Home Inc. 1331 Rockville Pike, Rockville, Maryland 20852 25a. DATE REC'D. BY REGISTRAR MAR 29 1985 25b. REGISTRAR'S SIGNATURE [Signature]

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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White

May 14, 1954

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West, D.C.

House

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10008 of London Lane 20000

John Henry Silver

Marvin

Collins

James

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Residence of James Taylor

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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081043

1- FOR-
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Lillian</i>			FIRST MIDDLE LAST <i>Kaplan</i>			2a DATE OF DEATH MONTH DAY YEAR <i>March 13, 1985</i>		2b HOUR <i>9:25 P</i>	
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>March 20, 1903</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>81</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a STATE <i>Maryland</i>		13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>1000 North Noyes Drive (20910)</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Pincus Laiefsky</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Mallinoff</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-46-6142</i>		17 INFORMANT <i>Bethesda, Maryland 20817 Dr. Donald Kaplan; 5912 Plainview Road;</i>					
18 CAUSE OF DEATH (Enter only one cause per line for a), b), and c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Mediastinitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <i>pm.</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Probable traumatic intubation - probably related to</i>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>8 P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>3-13</i> 19 <i>85</i> to <i>3-13</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3-13</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.									
22b. PHYSICIAN'S NAME (TYPE CURRENT)			22c. ADDRESS						
<i>Carroll D. Mahoney</i>			<i>3-14-85</i>						
23a BURIAL, CREMATION, REMOVAL <i>Burial</i>			23b. DATE <i>3/15/85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>King David Memorial Gdn; Falls Church; Fairfax; Va.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24 FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i> <i>1170 Rockville Pike; Rockville, Md. 20852</i>									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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081043

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE KATZMAN			2a. DATE OF DEATH MONTH DAY YEAR March 9, 1985		2b. HOUR 5:30 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 19, 1897		
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. UNDER 1 YEAR MONTHS DAYS 0 0		7. UNDER 24 HRS HOURS MIN. 0 0		
7a. BIRTH PLACE (STATE OR FOREIGN) Beltz Bessarabia Romania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Conv. & Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		
12b. KIND OF BUSINESS OR INDUSTRY Shop Keeper						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Pittle Shuster		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Ruth Shames				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-56-1164		17. INFORMANT ADDRESS Mrs. Ida B. Rosenheim (Same as # 13)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiopulmonary ArrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**INSTANT**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF -

(b) **Pneumonia****1 week**

DUE TO, OR AS A CONSEQUENCE OF -

(c) **arteriosclerotic heart disease****years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Cerebral arteriosclerosis

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 19 73 to March 9 19 85 , that (2) (we) last saw the deceased alive on Feb 18 19 85 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (3) we did not view the body after death.							
22b. SIGNATURE Morton W. Shapiro				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton W. Shapiro, M. D.				22e. ADDRESS 5225 Pooks Hill Road, Bethesda, Md. 20814			

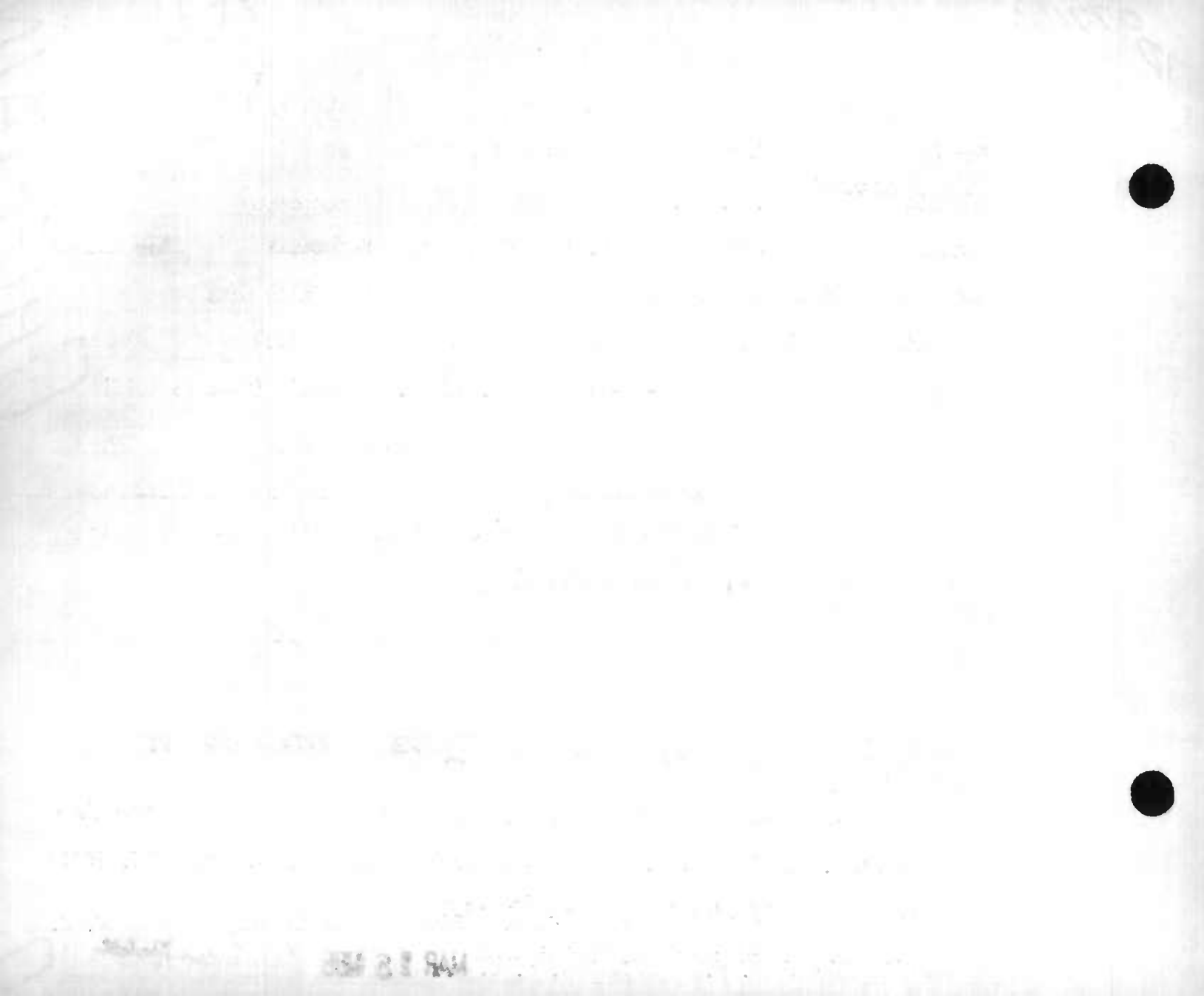
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/11/1985		23c. NAME OF CEMETERY OR CREMATORY Shev Shalom Talmud Torah Congregation		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D. C.	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR MAR 13 1985			
				25b. REGISTRAR'S SIGNATURE J. Davidson			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



081036

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

GEORGE

KELLY

1. DECEASED NAME (TYPE OR PRINT) George A. Kelly			2a. DATE OF DEATH MONTH DAY YEAR 03 13 85		2b. HOUR 8:10 AM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 01 09 02	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) freight handler		12b. KIND OF BUSINESS OR INDUSTRY R.R.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md. Calvert N. Beach			13c. CITY OR TOWN N. Beach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1 WHITE 508-16-4259		17. INFORMANT ADDRESS Montie Scott 2805 Lindell St. MD 20902	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>81</u> , to <u>March 13</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>March 13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/14/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/15/85	23c. NAME OF CEMETERY OR CREMATORY Md. Veterans	23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.
24. FUNERAL DIRECTOR NAME Rausch Funeral Home		25. DAY OF BURIAL, CREMATION, REMOVAL DATE 18 1985	
ADDRESS Cwings, Md.		SIGNATURE <u>[Signature]</u>	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LUKE CARROL KELLY			2a. DATE OF DEATH MONTH 3 DAY 21 YEAR 85			2b. HOUR M			
3. SEX Male		4. RACE BLACK		5. DATE OF BIRTH MONTH 6 DAY 19 YEAR 33		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS 51 DAYS 51 HOURS 51 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Sp. Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY Montg		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1340 Univ. Blvd. W.	
14. FATHER'S NAME FIRST Paul MIDDLE C. LAST Kelly		15. MOTHER'S MAIDEN NAME FIRST Bessie MIDDLE Dodson LAST Dodson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. 215-26-3743		17. INFORMANT Jeanette Kelly ADDRESS 1014 Quebec Tr. Silver Spring, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus DUE TO, OR AS A CONSEQUENCE OF (b) Tracheo Esophageal fistula. DUE TO, OR AS A CONSEQUENCE OF (c) Tracheo Esophageal fistula.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Tracheo Esophageal fistula.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. A. Chacko		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 209/10	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. A. CHACKO		22e. ADDRESS 8500, 16th St. Suite G-3, Silver Spring, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3-25-85		23c. NAME OF CEMETERY OR CREMATORY Mutual Mem. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montg Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. WASH. ST. Rockville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 27 1985		25b. REGISTRAR'S SIGNATURE John L. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS. TO THE GENERAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS. TO THE FUNERAL DIRECTOR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS. TO THE REGISTRAR: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE ADVISE THE DIVISION OF VITAL RECORDS.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Reginald E Keniston						2a. DATE KNOWN OF DEATH ESTIMATED March 22, 1985				2b. HOUR 10:30 AM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR May 18 1918		6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD March 22, 1985	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Manhasset MD.	
10. CITY OR TOWN OF DEATH Scituate				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUDIO VISUAL SPEC.		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.	
13a. STATE MD						13b. COUNTY Montgomery		13c. CITY OR TOWN Scituate		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST KENISTON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE PRESCOTT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II						16b. SOCIAL SECURITY NO. 001-10-6767		17. INFORMANT ADDRESS GLADYS C. KENISTON SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Leaking Suture Line DUE TO, OR AS A CONSEQUENCE OF (c) Abdominal Aneurysm Repair										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 2 weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION 3-22-85				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Leaking Abdominal Aortic Aneurysm Repair						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 18, PART 21c) Repair					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Rogers						TITLE (SPECIFY) Dep.		MEDICAL EXAMINER		DATE March 22 1985	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS						ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/26/85		23c. NAME OF CEMETERY OR CREMATORY CROWNSVILLE VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE CROWNSVILLE MARYLAND			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR APR 1 1985		25b. REGISTRAR'S SIGNATURE John Keniston			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ESTIL Joseph Kiouss			2a. DATE OF DEATH MONTH March DAY 10 YEAR 1985		2b. HOUR 10:20 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH December DAY 25 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5811 Lone Oak Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Elmer MIDDLE Nathan LAST Kiouss		15. MOTHER'S MAIDEN NAME FIRST Addie MIDDLE B. LAST Carter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 216-44-2634		17. INFORMANT ADDRESS Gadiehea Kiouss (WIFE) SAME AS #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 19 84 to 10 March 19 85 , that (I) (we) lost saw the deceased alive on 10 March 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John F. Gustafson		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John F. Gustafson, M.D.		22e. ADDRESS 5480 Wisconsin Ave Chevy Chase Md 20815			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE MARCH 11, 1985	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN RIVERDALE COUNTY PGCO. STATE MARYLAND
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		ADDRESS SILVER SPRING, M.D.		25a. DATE REC'D. BY REGISTRAR MAR 13 1985	25b. REGISTRAR'S SIGNATURE Davidson-Rendell

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stephan Kirzecky			2a. DATE OF DEATH March 11, 1985		2b. HOUR 10:47 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1 MONTH 8 1894	6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) Ukraine	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION priest		
12b. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md.	12b. COUNTY Mont.	12c. CITY OR TOWN S.S.	13. STREET ADDRESS / ZIP CODE 925 Schindler Drive 20903		
14. FATHER'S NAME (TYPE OR PRINT) Hryhory Kirzecky		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Maria Tychkowsky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 206 30 0668	17. INFORMANT Myron Kirzecky (Son)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 3-12 85, that (I) (we) last saw the deceased alive on 3-11 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Robert T. Thibadeau				22c. DATE SIGNED 3-12-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT T. THIBADEAU				22e. ADDRESS Rockville, MD 20852	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/15/85	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION City or Town County State Philadelphia, Penn.
24. FUNERAL DIRECTOR NAME Hines/Rinaldi			25a. DATE REC'D. BY REGISTRAR MAR 15 1985		
25b. REGISTRAR'S SIGNATURE J. Davidson-Randall					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				ANNA JOSEPHINE KMETZ			
1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OF PRINT) ANNA J. KMETZ				2a. DATE OF DEATH MONTH 3 DAY 13 YEAR 85			
2b. HOUR 4:25 PM							
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH March DAY 27 YEAR 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baker PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Siber Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Delaware Hospital		12a. USUAL OCCUPATION (KIND OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE 13a. STATE PA		13b. COUNTY FAYETTE		13c. CITY OR TOWN FAYETTE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 29 MAPLE ST., 99999		14. FATHER'S NAME FIRST Joseph MIDDLE Pasternack LAST Mary		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Kozlinsky LAST Kozlinsky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 177-50-1548		17. INFORMANT MARTIN J. KMETZ		ADDRESS 2311 HUDGEN VALLEY LA. SS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Hemorrhage				1 WEEK			
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis				YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) DIABETES mellitus, GANGRENE of Right LEG							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from 2/27/85 to 3/13/85 , that (ii) (we) last saw the deceased alive on 3/13/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not see the body after death, so state.)							
22b. SIGNATURE M. Shapiro				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Mort Shapiro				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (TYPE OF PRINT) Burial		23b. DATE MARCH 18, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN Fayette Co, Uniontown, Pa.	
24. FUNERAL DIRECTOR L. J. Walters		ADDRESS 254 Carroll St. N. W.		25a. DATE REC'D. BY REGISTRAR MAR 15 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Alma Marion Koehl</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>3-4-85</i>			2b. HOUR <i>12²⁵ PM</i>			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR <i>MAY 20, 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i>		7. UNDER 1 YEAR MONTHS DAYS <i>YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARTIST		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 515 MANSFIELD ROAD 20910	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY SCHLOTHEUBER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMA KRIEGE^{1ST}					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-12-2094		17. INFORMANT ADDRESS GEORGE KOEHL, HUSBAND, SAME AS ITEM #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

Intracerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <i>3/1/85</i> , 19____, to <i>3/3/85</i> , 19____, that (he/she) last saw the deceased alive on <i>3/3/85</i> , 19____, and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert Gerwin</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/4/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert Gerwin MD</i>		22e. ADDRESS <i>7500 Harover Pkwy, Greenbelt Md 20770</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE <i>3/4/85</i>		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA, VIRGINIA	
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASH., D.C. 20009				25a. DATE REC'D. BY REGISTRAR MAR 8 1985			
				25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

THE JOURNAL

• **2008** – **100th Anniversary**

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

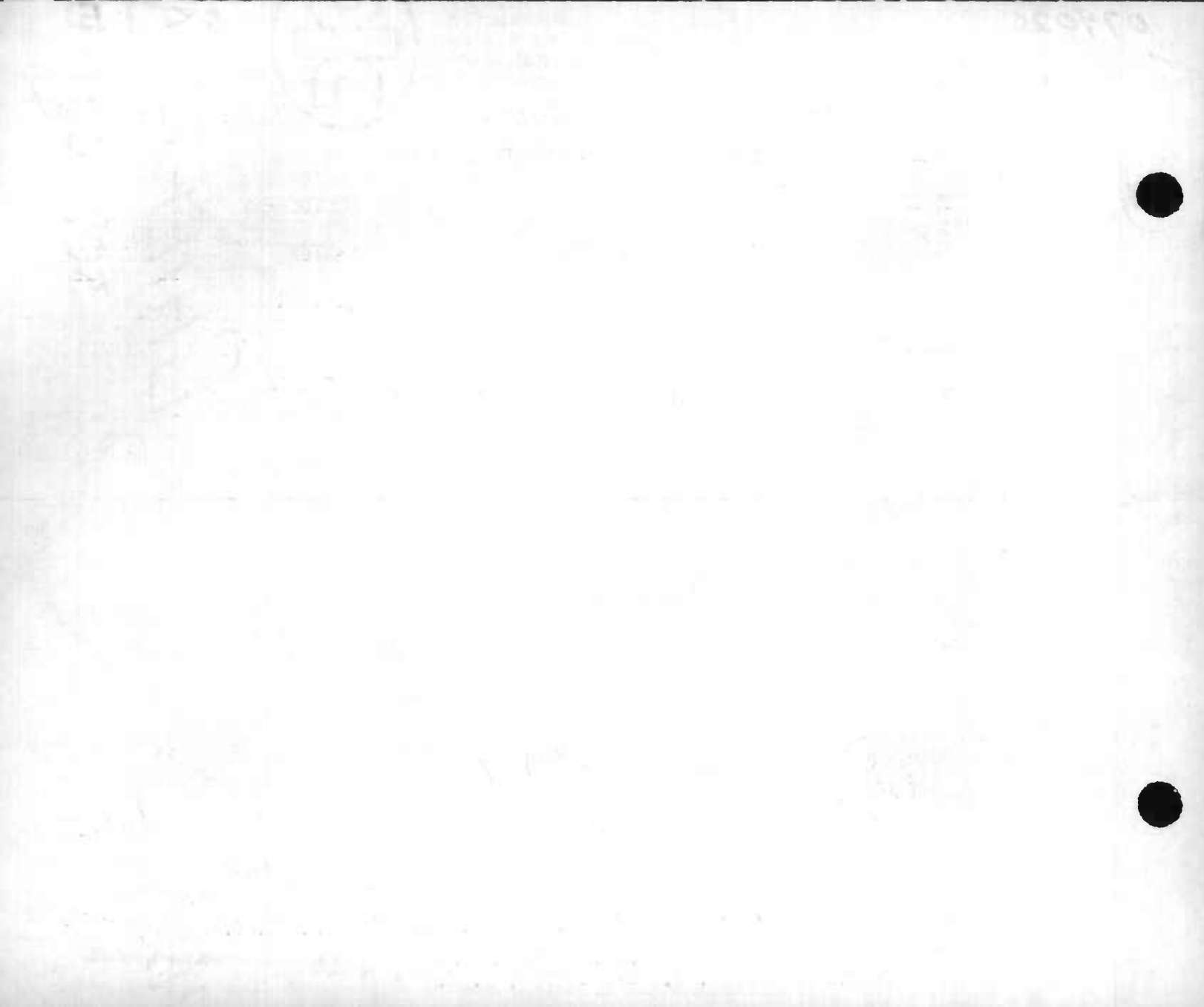
1. DECEASED NAME (TYPE OR PRINT) YAGHOUB			2a. DATE OF DEATH MONTH March DAY 11 YEAR 1985			2b. HOUR 430 ^M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 28, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN		7b. CITIZEN OF WHAT COUNTRY? IRAN		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF DUTY OR MOST OF WORKING LIFE) CANTOR		12b. KIND OF BUSINESS OR INDUSTRY SYNAGOGUE		
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME ELTANHOU MIDDLE KOHAN					15. MOTHER'S MAIDEN NAME RACHEL MIDDLE (UNASCERTAINABLE)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN)		16b. SOCIAL SECURITY NO. none		17. INFORMANT IRADJ KOHEN, 4417 MAHAN ROAD, WHEATON, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) septic shock DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) chronic dementia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 1984 to March 11, 1985 , that (I) (we) last saw the deceased alive on March 10, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did not) view the body after death.										
22b. SIGNATURE Mark S Rosen MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/11/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark S Rosen, MD			22e. ADDRESS Silver Spring, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/12/1985		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ADDELPHI, GEORGE'S PRINCE MARYLAND			
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.										
25a. DATE REC'D. BY REGISTRAR APR 14 1985 REGISTRAR'S SIGNATURE Jane Harrison-Konrad										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or in 18 state any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Evelyn E. Kraft				2a. DATE KNOWN OF DEATH ESTIMATED 3 10 85 19				2b. HOUR 11:00 P M											
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 20 1926 8-20-23		6. AGE IN YEARS (BIRTHDAY) 61 TRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 3 10 85 19		7d. HOUR 12 P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD							
10. CITY OR TOWN OF DEATH Chevy Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4550 N. Park Avenue, #612				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY Own Home							
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Chevy Chase				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4550 N. Park Ave. 20815 #612			
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Chesivoir				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Fanaroff				17. INFORMANT Robert L. Peskin, Son, 4879 Chevy Chase Dr., Chevy Chase, MD 20815											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-26-6695															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asphyxiation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) Hanging DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE John Tauber				TITLE (SPECIFY) M.D. <i>John Tauber</i>				MEDICAL EXAMINER				DATE SIGNED 3-10-88							
EXAMINER'S NAME (TYPE OR PRINT) John Tauber				ADDRESS 8218 Wisconsin Ave															
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 3/13/85				23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden				23d. LOCATION (CITY OR TOWN) Bethesda, Md. STATE							
24. FUNERAL DIRECTOR NAME ADDRESS Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C. 20016																			
25. REGISTRAR'S SIGNATURE DATE MAR 18 1988																			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

051033

Weylin

Female, white, 20, 1923

Virginia

Gray Chane, 4830 N. 1st Avenue, 612

Weylin, Montgomery, Gray Chane, 4830 N. 1st Avenue, 612

Gray Chane

Gray Chane

Gray Chane

Gray Chane, 4830 N. 1st Avenue, 612
Gray Chane, 4830 N. 1st Avenue, 612

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Gray Chane, 4830 N. 1st Avenue, 612

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pauline R. Krantz		2a. DATE OF DEATH MONTH DAY YEAR 03 11 85		2b. HOUR 11:49 AM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02 10 21		6. AGE (IN YEARS LAST BIRTHDAY) 64	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady		12b. KIND OF BUSINESS OR INDUSTRY Men's Clothing
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. ZIP CODE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Edwin Goff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Randall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 004-18-0856		17. INFORMANT ADDRESS Victor E. Krantz, Husband, 3344 Claridge Court, Wheaton, MD 20902	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) chronic obstructive lung disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12 MAY 19 78 to 11 MAR 19 85 that (I) (we) last saw the deceased alive on 11 MAR 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hubert J. Alpert		DEGREE MD		22c. DATE SIGNED 11 MAR 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, MD		22e. ADDRESS 8630 FENTON ST SILVER SPRING, MD 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/13/85		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Suitland, Maryland		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisconsin Avenue, N.W., Washington, D.C. 20016			
25a. DATE REC'D. BY REGISTRAR MAR 18 1985		25b. REGISTRAR'S SIGNATURE John Randolph			

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MEDICAL CERTIFICATION

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9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

203 COTTON 203

Joseph G. Miller's Sons, Inc., 2130 Wisconsin Avenue, N.W., Washington, D.C. 20006
Cedar Hill Cemetery, Suitland, Maryland

004-18-0856

Victor A. Kuntz, Husband,
Court, Weston, MD 20902

Blanche Edwin Goff

Fluence

Randall

Marjorie

Montgomery

34th Justice Court 20902

White

Pauline

Kuntz

03 11 22 1144

08215A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

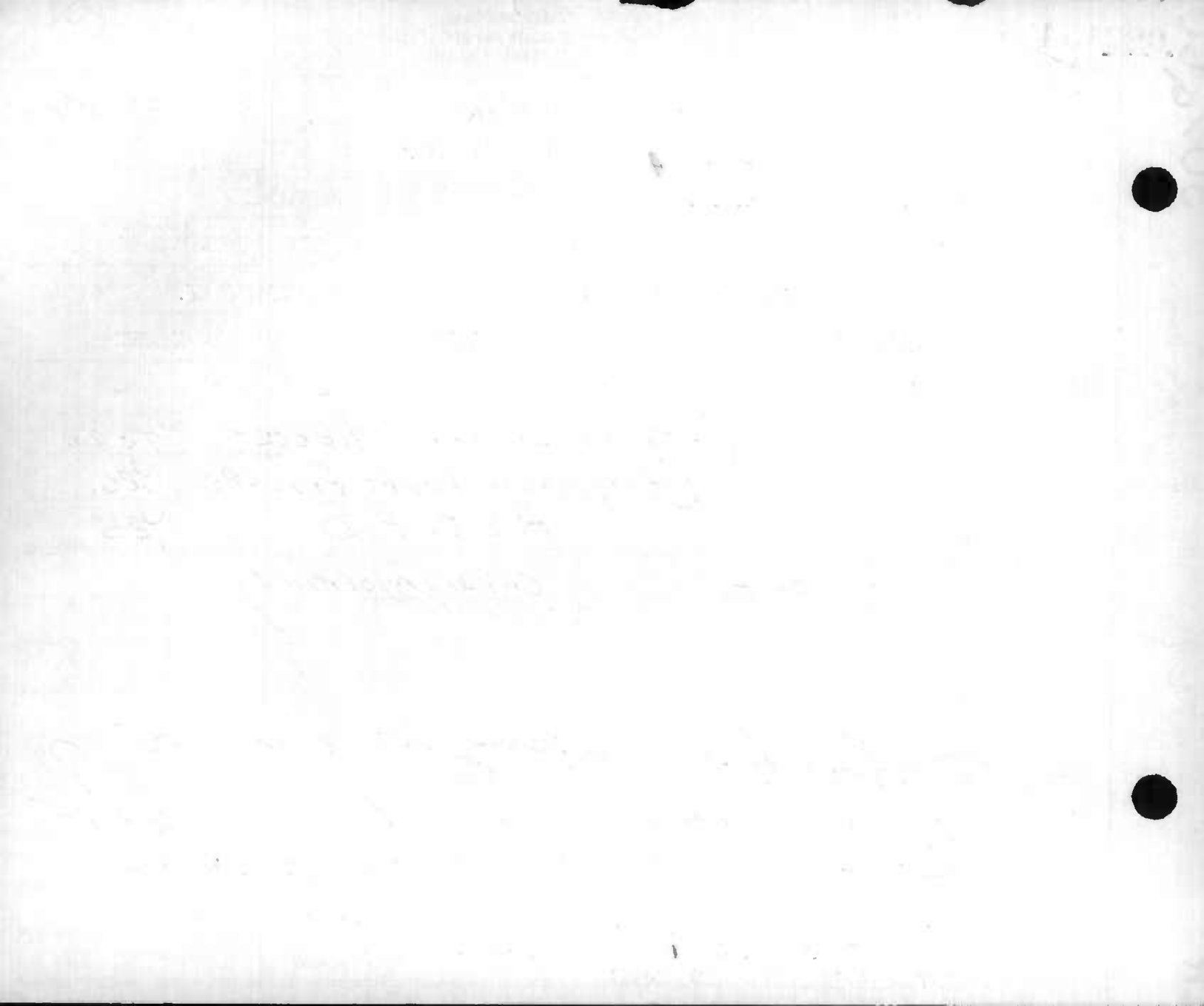
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) E. ARL K. KREMER			2a. DATE OF DEATH MONTH DAY YEAR 3-2-85		2b. HOUR 9:15 P.M.
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH OCT 13 1904		6. AGE (IN YEARS LAST BIRTHDAY) 80	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) PENNA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SHARON NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS) PASSENGER AGENT	12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE ALLEN KREMER		15. MOTHER'S MAIDEN NAME MIDDLE AMANDA KEYSER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 701-05-8595		17. INFORMANT ADDRESS JEAN KREMER SAME AS 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE					YES.
DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.H.D					YES.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CACHEXIA ; CARDIOMYOPATHY					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/22/85 to 3/2/86 that (I) (we) last saw the deceased on (above) 3/2/86 and that in my (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE D. E. Lewis		DEGREE M.D.		22c. DATE SIGNED 3/2/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E. LEWIS		22e. ADDRESS OLNEY, MD 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MARCH 6, 1985	23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		25a. DATE REC'D. BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE John Davidson	
WEST, SILVER SPRING, MD 20901					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 2) should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Chang

Yun

Kuo

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

3

13

85

0945AM

3 SEX

Female

4 RACE

Oriental

5 DATE OF BIRTH

MONTH

DAY

YEAR

Feb.

18,

1907

6 AGE (IN YEARS LAST BIRTHDAY)

78

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Taiwan

7b. CITIZEN OF WHAT COUNTRY?

Taiwan

8 MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD.

10 CITY OR TOWN OF DEATH

Rockville

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Shady Grove Adventist Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

Own Home

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

Maryland

13c. COUNTY

Montgomery

13d. CITY OR TOWN

Potomac

13e. INSIDE CITY LIMITS?

YES ☐NO ☒

13f. STREET ADDRESS / ZIP CODE

11312 Berger Terrace/20854

14 FATHER'S NAME

First

Fin

MIDDLE

LAST

Su

15. MOTHER'S MAIDEN NAME

First

Not

MIDDLE

Available

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17 INFORMANT

216-06-5744

ADDRESS

James Kuo, same as #13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Circulatory failure

DUE TO, OR AS A CONSEQUENCE OF

(b)

Septic

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

myocardial infarction Diabetes mellitus Liver Neoplasm

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-12, 1985, to 3-13, 1985, that (I) (we) lost

saw the deceased alive on 3-13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

ATTENDING

MEDICAL

STAFF

PHYSICIAN ☒DIRECTOR ☐PHYSICIAN ☐23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Cremation

23b. DATE

March 15, 1985

23c. NAME OF CEMETERY OR CREMATORY

Metropolitan Crem.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Alexandria, Virginia

24 FUNERAL DIRECTOR Robert A. Pumphrey Funeral

Homes, P.A. Rockville, Maryland 20850

25a. DATE REC'D. BY REGISTRAR

MAR 18 1985

25b. REGISTRAR'S SIGNATURE

S. Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

079119

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08920	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Torgren K. Kvastad										2a. DATE KNOWN OF DEATH ESTI. MATED March 9 1985	
1. SEX Male 4. RACE W 5. DATE OF BIRTH MONTH DAY YEAR April 30 87 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 87 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 8. IF UNDER 24 HRS. 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD										2b. DATE PRONOUNCED DEAD March 7 1985	
10. BIRTHPLACE (STATE OR FOREIGN) Norway 11. CITIZEN OF WHAT COUNTRY? U.S.A. 12. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										13. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre N.H. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Accountant 12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1714 Mark Lane 20852											
14. FATHER'S NAME FIRST MIDDLE LAST Lars Kvastad 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhemina Moland											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WW I 16b. SOCIAL SECURITY NO. 065-07-8298 17. INFORMANT Deerfield Beach, Fla. 33442 Dolly O. Murphy 386 Deer Creek Run											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) terminal Bronchial Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fracture L hip											
19a. DATE OF OPERATION 12/15 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fract. L hip 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 126 1985 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall in N.H.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N.H. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Bel Pre Rd. Silver Spring Montgomery MD											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John S. Rogers TITLE (SPECIFY) Medical Examiner DATE SIGNED March 10 1985											
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers ADDRESS 1919 Seminary Rd. Silver Spring, Md. 20910											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation 23b. DATE 3/11/85 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland											
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 25a. DATE REC'D. BY REGISTRAR MAR 15 1985 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall											

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

ORIGINAL FILED

NOV 10 1963

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087026

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-B4
25M

BP

DHMH - 17
(VR A15 ME (5))1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
EDNA F. LAKE								3-17-85		19						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
FEMALE	WHITE	OCT 15, 1892		92 YRS.						3-17-85		19				M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NEW YORK		U.S.A.				Montgomery County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Silver Springs		Holy Cross Hospital		HEAD MISTRESS		GIRLS SCHOOL											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		MONTGOMERY		WHEATON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		901 ARCOLA AVE 20902									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
THEODORE		EMMA															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		275-30-2108		ELIZABETH E. VANCE		10317 DETRICK AVE. KENNINGTON, MD. 20892											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. (HEAD ONLY) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. (HEAD ONLY) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Margarita A. Korell</u>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 3-18-85													
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 3-19-1985		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE P.G.C. Md.											
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		ADDRESS SILVER SPRING, Md.		25a. DATE RECEIVED BY REGISTRAR MAR 22 1985		25b. REGISTRAR'S SIGNATURE											

100% COTTON FIBER

WHEATON POWER



079007

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 2 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY KATHLEEN LA ROSE			2a. DATE OF DEATH MONTH DAY YEAR 3/14/85		2b. TIME 5:59p M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 17 1929		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Vice President		12b. KIND OF BUSINESS OR INDUSTRY Bank		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 12928 Georgia Ave., 20906			14. FATHER'S NAME FIRST MIDDLE LAST Stanley Kreiler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Henry			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Peter F. LaRose-husband-(same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myelogenous Leukemia in Blastic Crisis 8 weeks</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) did not attended the deceased from <u>Mar. 16,</u> 19 <u>84</u> to <u>Mar. 14,</u> 19 <u>85</u> that (I) xx last saw the deceased alive on <u>Mar. 14,</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Jules Lodish M.D.</u>				DEGREE M.D.		22c. DATE SIGNED 3/14/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULES LODISH M.D.				22e. ADDRESS 2901 Olney-Sandy Spring Rd. Olney, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Mar. 18, 1985		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 15 1985		
				25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100000



082155

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KEVELLA R. LARSSON			2a. DATE OF DEATH MONTH DAY YEAR 3 9 85			2b. HOUR 9:34 P.M.						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 23 09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 27800 Barnes Road 20872		
14. FATHER'S NAME FIRST MIDDLE LAST John Ryden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Young								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS Magnus Y. Larsson-husband-(same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Viral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Parkinson's Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/20/85</u> 19 <u>85</u> to <u>3-9-</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-9-85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Tibor E. Frekko M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/10/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tibor E. Frekko, MD.				22e. ADDRESS 19211 Montg. Village Ave., Gaithersburg, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 13, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 11 1985						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.

BP

NUMBER

10000

20%



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 2 4

1- FOR
STATE
REGISTRAR

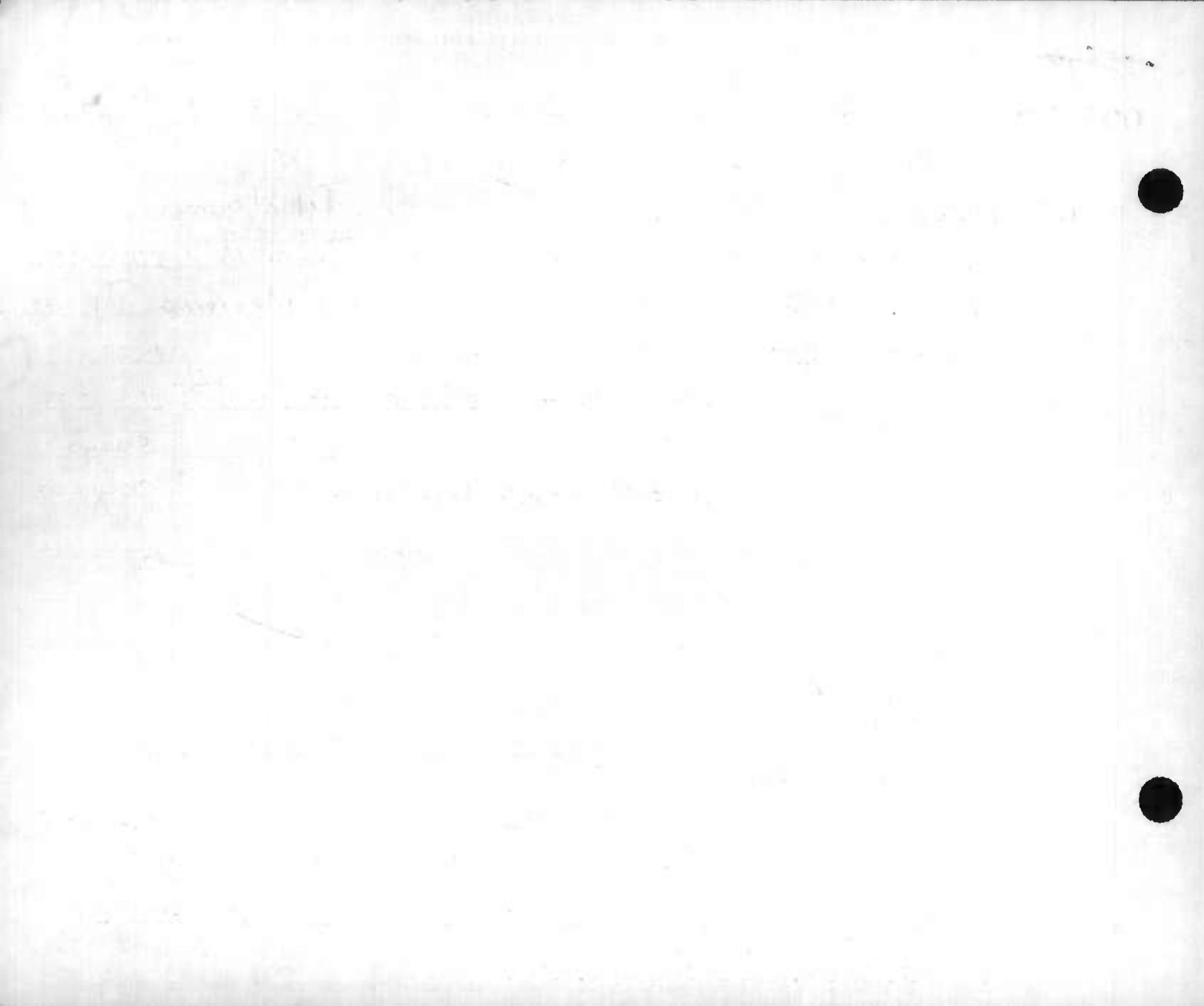
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS BORDEN LARUE			2a. DATE OF DEATH MONTH DAY YEAR 3 27 85		2b. HOUR 0200 AM						
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 12 07		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					
10. CITY OR TOWN OF DEATH Tolcoma Pk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp				12a. USUAL OCCUPATION (TYPE OF BUSINESS, SERVICE, OR WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY SINGER-LINK			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY P.G. 13c. CITY OR TOWN Adelphi 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE 1914 Merremac Dr. 20783											
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS HENRY LARUE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEULAH DAWSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-07-4044		17. INFORMANT X XXXXXX MARY S. LARUE wife		ADDRESS SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) ALZHEIMER'S DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MARCH 22 1985 to MARCH 26 1985 that (I) (we) last saw the deceased alive on MARCH 26 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Patricia A. Gurny			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICIA A. GURNY			22e. ADDRESS 11161 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/29/85		23c. NAME OF CEMETERY OR CREMATORY PHILO LODGE CEMETERY			23d. LOCATION WESTERNPORT ALLEGHENY STATE MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR APR 1 1985			25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For information, the law also requires that the death certificate be signed by the attending physician or the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use at the burial-transit permit. Then please remove carbonpapers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

094014

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8508925

1 DECEASED NAME (TYPE OR PRINT) WARD E. LATTIN			2a DATE OF DEATH MONTH DAY YEAR MARCH 28, 1985			2b HOUR M				
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR JULY 30, 1905		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH SILVER SPRING		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1131 UNIV. BLVD., WEST				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LAWYER		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE MARYLAND			13b COUNTY MONTGOMERY		13c CITY OR TOWN SILVER SPRING		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1131 UNIV. BLVD., W., 20902	
14 FATHER'S NAME FIRST MIDDLE LAST ELMER LATTIN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 678-30-2903		17 INFORMANT DAUGHTER DIANE L. LATTIN, WHEATON, MD. 20902					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) this hospital attended the deceased from 12/23/83 to 3/27/85 , that (b) we last saw the deceased alive on 3/27/85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (b) we (did) (did not) view the body after death.										
22b SIGNATURE William Jacobs						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/28/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) William Jacobs						22e ADDRESS 600 New Hampshire Avenue N.W. Wash., D.C.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 3/30/85		23c NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.			
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a DATE REC'D. BY REGISTRAR APR 1 1985		25b REGISTRAR'S SIGNATURE Lia Davidson-Randall		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

MEDICAL CERTIFICATION

001014

WARD

LATTIN

MARCH 28, 1962

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FOX COLTON FIBRE
LITTON BUILD

Section Jacob

800 New Hampshire Avenue N.W. Wash., D.C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Cleo Franklin Layton			2a DATE OF DEATH MONTH DAY YEAR March 30, 1985		2b HOUR 9:35 am
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH DAY YEAR July 25, 1916	6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS	7b HOUR 9:35 am	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD.		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK OR BUSINESS IN LIFE) Assistant Administrative	12b KIND OF BUSINESS OR INDUSTRY Dept. Interior	
13a STATE Maryland			13b COUNTY Montgomery	13c CITY OR TOWN Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Cleo Gay Layton			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Burgstresser		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 223 60 6454	17 INFORMANT ADDRESS Janet B. Layton, wife see # 13		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Ischemic Heart Disease</u>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	

22a I certify that (I) (the undersigned) attended the deceased from 19 82, to 3/30 19 85, that 4 (we) last saw the deceased alive on Feb 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) did not view the body after death.

22b SIGNATURE <u>Frank N. Gravano</u> MD	DEGREE MD	22c DATE SIGNED <u>3/31/85</u>
22d PHYSICIAN'S NAME (TYPE OR PRINT) Frank N. Gravano, MD	22e ADDRESS 10313 Georgia Ave, Silver Spring, MD	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE Apr. 2, 1985	23c NAME OF CEMETERY OR CREMATORY Brown's Mill Cemetery	23d LOCATION CITY OR TOWN COUNTY STATE Antrim Twp, Franklin, Penna
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA		25a DATE OF D. BY REGISTRAR APR 8 1985	25b REGISTRAR'S SIGNATURE <u>[Signature]</u>
300 West Montgomery Ave Rockville, Md. 20850			

100027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is completed, item 18 must be left blank.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR I.J. STATE REGISTRAR		Also known as Lee Yu Hung							
1 DECEASED NAME (TYPE OR PRINT)		FIRST YU		MIDDLE WOO		LAST LEE		2a DATE OF DEATH MONTH DAY YEAR 03 14 85 2b HOUR 3:10A.M.	
3 SEX male		4 RACE Oriental		5 DATE OF BIRTH MONTH DAY YEAR 02 19 99		6 AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) China		7b CITIZEN OF WHAT COUNTRY? China		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS) Laundry owner		12b KIND OF BUSINESS OR INDUSTRY C.Woo Laundry	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 13006-Tamarack Road 20904	
14 FATHER'S NAME FIRST MIDDLE LAST Hai Kai Lee		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lau Ngan Shuey							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 577-50-6769 A		17 INFORMANT ADDRESS Sen How Lee (Wife) Same as # 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic Acidosis, DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs. more than 3 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Anemia, Cerebrovascular Accident									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/7/85, 19 to 3/14, 19 85, that (I) (we) last saw the deceased alive on 3/13/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hsueh		DEGREE		22c. DATE SIGNED 3/15/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. S. PUAR		22e. ADDRESS 12450 Parklawn Dr. Rockville MD 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 17, 85		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. George Co., MD			
24. FUNERAL DIRECTOR J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Reva LeFKOV			2a. DATE OF DEATH MONTH DAY YEAR MARCH 13, 85			2b. HOUR 950A M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 18 1906		6. AGE (IN YEARS (LAST BIRTHDAY)) 78		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (WORKING LIFE) OFFICE CLERK			
12b. USUAL RESIDENCE (# NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 2502 VAN BUREN STREET		13c. STREET ADDRESS / ZIP CODE 20782			
14. FATHER'S NAME FIRST MIDDLE LAST ISRAEL JACOB LEFKOV		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BELLA MASEYAV							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 067-20-2123		17. INFORMANT 6708 WEST PARK DRIVE SAMUEL LEFKOV, WEST HYATTSVILLE, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Chronic Obstructive Pulmonary Dis DUE TO, OR AS A CONSEQUENCE OF emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/13/85 to late , that (I) (we) last saw the deceased alive on 3/13/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Thos G. Ward		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/13/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		22e. ADDRESS 6116 Robinwood Bethesda 20817							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/15/1985		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA			
24. DONOR OF ORGAN OR TISSUE (NAME AND ADDRESS) DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.									

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, registration should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

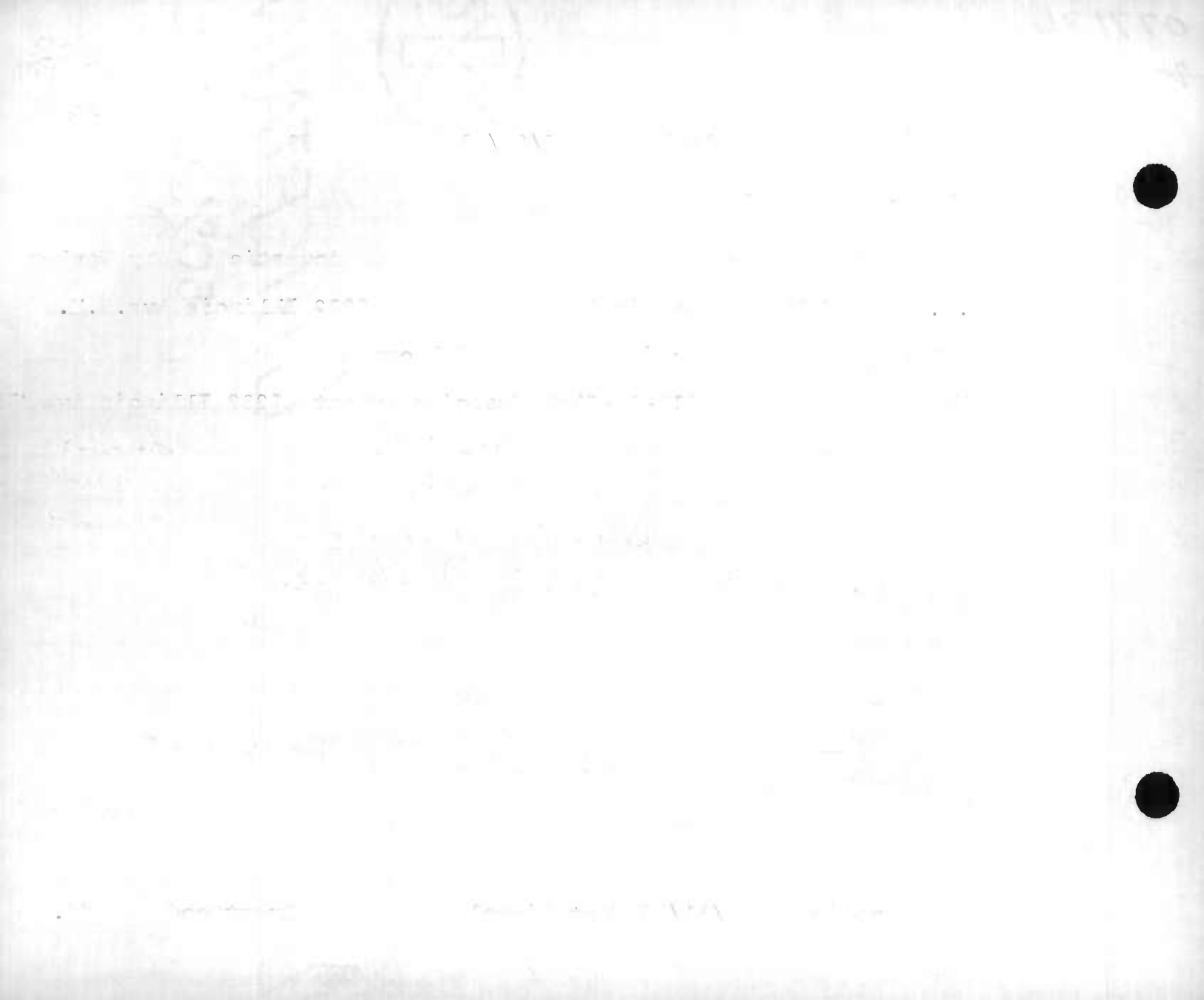
8 5 0 8 9 2 8
REG. NO. 3 58 PM

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
LULA Lewis		3 4 85		3 58 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. UNDER 1 YEAR	
Female	Black	5/20/01	83	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH		
Oklahoma	USA	NEVER MARRIED	Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	12a. USUAL OCCUPATION			
Bethesda	Suburban Hospital	domestic			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	14. FATHER'S NAME	
D.C.	USA	Washington	5232 Illinois Ave. N.W.	Tom Lewis	
15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
Unknown	No	218-30-3724	Francine Bryant	5232 Illinois Ave NW	
18. CAUSE OF DEATH					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Cerebral pulmonary embolism</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Malnutrition Dehydration</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Refractory Anemia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Nephroclerosis & Globular Multiple Sclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED	
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
(IF EITHER, NOTIFY MEDICAL EXAMINER)		P.M. 19			
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION	
AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Jan 25, 1985, to March 4, 1985, that (I) (we) lost saw the deceased alive on Jan 31, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Wm M. Kelley		M.D.		March 5 1985	
22d. PHYSICIAN'S NAME		22e. ADDRESS			
(TYPE OR PRINT)					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
(SPECIFY) Cremation		3/11/85		Fort Lincoln	
23d. LOCATION		23e. COUNTY		23f. STATE	
Brentwood		Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		15 1985		John W. Plunkett	
LAWRENCE W. PLUNKETT		3619-14th ST			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner may be notified of cause.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For 4 days after death, the certificate may be executed by the funeral director or other person authorized by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified within 24 hours of death.

BP _____

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>SAUS</i> <i>B.</i> <i>LIEBGOLD</i>		2a. DATE OF DEATH MONTH DAY YEAR 3-7-85		2b. HOUR 5 ⁰⁰ A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH July 4, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 85	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD		
10. CITY OR TOWN OF DEATH Wheaton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary (Ret.)	12b. KIND OF BUSINESS OR INDUSTRY Printing	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Becker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta Durst			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 066-14-3639A		17. INFORMANT ADDRESS Maryland 20906 Sidney Liebgold; 3204 Gleneages Drive; S.Spg.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CVA + pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 weeks</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM TO PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Gustav S. Beland</i> 107 1st St. N. Elmont, L.I., New York	
22a. I certify that (I) (this hospital) attended the deceased from <i>6-1-19-1922</i> to <i>3-7-85</i> , that (I) <i>did</i> did not saw the deceased alive on <i>3-7-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Gustav S. Beland</i>		DEGREE M.D.		22c. DATE SIGNED 7/10/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GUSTAV S BELAND		22e. ADDRESS 14500 511 Ave Medical Center Spring Md. 20909			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/85		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Elmont., L.I., New York		24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHPLS. NAME 1170 Rockville Pike; Rockville, Md. 20852			

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 5 0 8 9 3 1
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Adele S Lindquist			2a. DATE OF DEATH MONTH DAY YEAR 3-6-85			2b. HOUR 4:05 pm				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 20 1886		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norway		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Luther Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9701 Viers Dr., 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Axel Neumann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stefanie Knag			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 578-62-2962			17. INFORMANT ADDRESS Port Charlate, Fla. Lillian Vogel, 169 N.W. Carlisle Ave.,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Insanition DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Alzheimer's Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 8 years										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from May 2, 1977 to March 6, 1985 , that (I) we lost saw the deceased alive on March 6, 1985 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did did not view the body after death.										
22b. SIGNATURE Harold F. McCann			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-7-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F. MCCANN			22e. ADDRESS 3355-16th St N.W. WASH. D.C. 20010							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/8/1985		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY COUNTY STATE Suitland Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.					25a. DATE REC'D. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, complete and sign page 3 of the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon patient permit and send it to the funeral home 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Female	White	April 20 1888	98
Norman	U.S.A.	x	Montgomery
Rockville	National Luther Home	Home	9701 Vista Dr., 20853
Mr.	Montgomery Rockville		
Neil	Hennemann	Stelania	Port Charles, La.
No	578-62-262	William Vogel, 199 N.W. Corlies Ave.,	

2100 Ave. N.W., Wash., D.C.
 Joseph Hewitt's Inc.
 3/8/1965
 Cedar Hill Cemetery
 Baltimore Maryland

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Ernest		Male		White	
Lipscomb		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
		Aug 14 1896		88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Washington D.C.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
Silver Spring		12007 Saint Dunston Lane		Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
				Mail Clerk	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		20906	
Geographic		12007 Saint Dunston Lane			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Silver Spring			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
Philip Daniel Lipscomb		Bertha Barbour		No	
		12007 Saint Dunston Lane Silver Spring Md.		16b. SOCIAL SECURITY NO.	
				579-48-8156	
				17. INFORMANT ADDRESS	
				Mary L. Ridgely Daughter.	
18. CAUSE OF DEATH (Enter only one cause per line for part 1a, and 1c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cardiopulmonary arrest		5 min	
DUE TO, OR AS A CONSEQUENCE OF (b)		Congestive heart failure		3 mo	
DUE TO, OR AS A CONSEQUENCE OF (c)		Coronary artery disease		10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
Diabetes mellitus, Blindness, Peripheral vascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 2/27, 19 75, to 3/17, 19 85, that (1) (we) last saw the deceased alive on 3/14, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not view the body after death.)					
22b. SIGNATURE DEGREE		22c. DATE SIGNED			
George S. Kenton MD		3/17/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
GEORGE S. KENTON		10620 GEORGIA AVE SILVER SPRING, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		3/20/85		Manassas Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Manassas Virginia		MAR 26 1985		J. E. Kenton	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS			
Baker Funeral Home		9320 West St. Manassas Va.			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

088021

1. DECEASED NAME (TYPE OR PRINT) MILDRED L LUKAT			2a. DATE OF DEATH MONTH DAY YEAR MARCH 22, 1985		2b. HOUR 5:32 AM
3 SEX FEMALE	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 24 1920		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C..	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10 CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Fisher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Schneider		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO 579-07-1445		17 INFORMANT Barbara Homer -sister- ADDRESS Apt. 3-C 3501 Forest Edge Drive Silver Spring, Md. 20906	
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE Lung disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION					
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 21 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J.J. Merendino, MD		DEGREE MD		22c. DATE SIGNED 3/22/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.J. Merendino, MD		22e. ADDRESS 11620 Kemp Mill Road, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-23-1985		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home Silver Spring, Md.			
25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE Golia Davidson-Randall			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THOMAS F MAHONEY			2a. DATE OF DEATH MONTH DAY YEAR 3 14 85		2b. HOUR 7:40 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 7 04		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	7. UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT. MD.	
10. CITY OR TOWN OF DEATH TR PK MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (THE WORK FOR MOST OF WORKING LIFE) Electrician	12b. KIND OF BUSINESS OR PROFESSION Retired	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 1805 Marden Lane, Olney, Md.		13c. CITY OR TOWN Olney	
14. FATHER'S NAME (PRINT) Thomas		15. MOTHER'S MAIDEN NAME (PRINT) Terese Farrell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
17. SOCIAL SECURITY NO. 088-02-8233		18. INFORMANT Thomas Mahoney		19. ADDRESS 1805 Marden Lane, Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Metastatic carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic carcinoma of prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days 6 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1984, to March 14, 1985, that (I) (we) last saw the deceased alive on March 13, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Eino Magi		DEGREE M.D.		22c. DATE SIGNED 3-14-1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EINO MAGI		22e. ADDRESS 11120 New Hampshire Av., Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Mar. 14/85		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE QUEENS - N.Y.		23e. DATE REC'D. BY REGISTRAR MAR 18 1985			
23f. REGISTRAR'S SIGNATURE Julia Davidson-Rodden					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 08935			
1. DECEASED NAME (TYPE OR PRINT) Helen A. Margus				2a. DATE OF DEATH MONTH DAY YEAR 3-13-85			
3 SEX Female				2b. HOUR 4:30 PM			
4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 10 28 27		6 AGE (IN YEARS LAST BIRTHDAY) YRS 57		7b. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Sub. Trust	
13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 9808 Braddock Road 20903		14 FATHER'S NAME FIRST MIDDLE LAST James Culbert		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pauline Reiner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 211-22-0339		17 INFORMANT ADDRESS Peter J. Margus- son- (same as 13e)			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Chronic renal failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 24 hrs							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from May 19 84 to 3/13 85 , that (1) (we) lost 3/13 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE Mark Rosen				22c. DATE SIGNED 3/14/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Rosen	
22e. ADDRESS Silver Spring, MD				22f. DATE SIGNED 3/14/85		22g. SIGNATURE John Rinaldi	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Tower City Schuylkill Penna.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		24b. ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 15 1985		25b. REGISTRAR'S SIGNATURE John Rinaldi	

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RECEIVED

NOT AFFECTED



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Betty E. Marseglia		2a. DATE OF DEATH MONTH DAY YEAR March 3, 1985		2b. HOUR MIN. 3:11P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 24, 1919		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 65	
7a. BIRTHPLACE (STATE OR FOREIGN) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (IF WORKING, GIVE WORKING LIFE) Wheaton Nursing Home		12b. KIND OF BUSINESS OR INDUSTRY Adm.
13a. STATE Md.		13b. COUNTY Mont	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pasquale Torcasio		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Raffael Torcasio			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 217 14 7304A		17. INFORMANT Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest CARDIAC ARREST					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MASSIVE ELECTROLYTE + FLUID IMBALANCE					
DUE TO, OR AS A CONSEQUENCE OF (c) GRAM NEGATIVE SEPTICEMIA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) PNEUMONIA KIDNEY FAILURE, ISCHEMIC CARDIOMYOPATHY, DIABETES MELLITUS, CHF					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4323 Havard Street, Silver Spring, Md. 20906	
22a. I certify that (I) (this hospital) attended the deceased from 2/14 , 19 85 , to 3/3 , 19 85 , that (I) (we) lost saw the deceased alive on 3/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard P. Delaney		22c. DEGREE M.D.		22d. DATE SIGNED 3/3/85	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.		22f. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 3/6/85		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Maryland		23e. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi 11800 New Ham. S.S. Md.			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

MAR 11 1985

7-15-29



074107

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

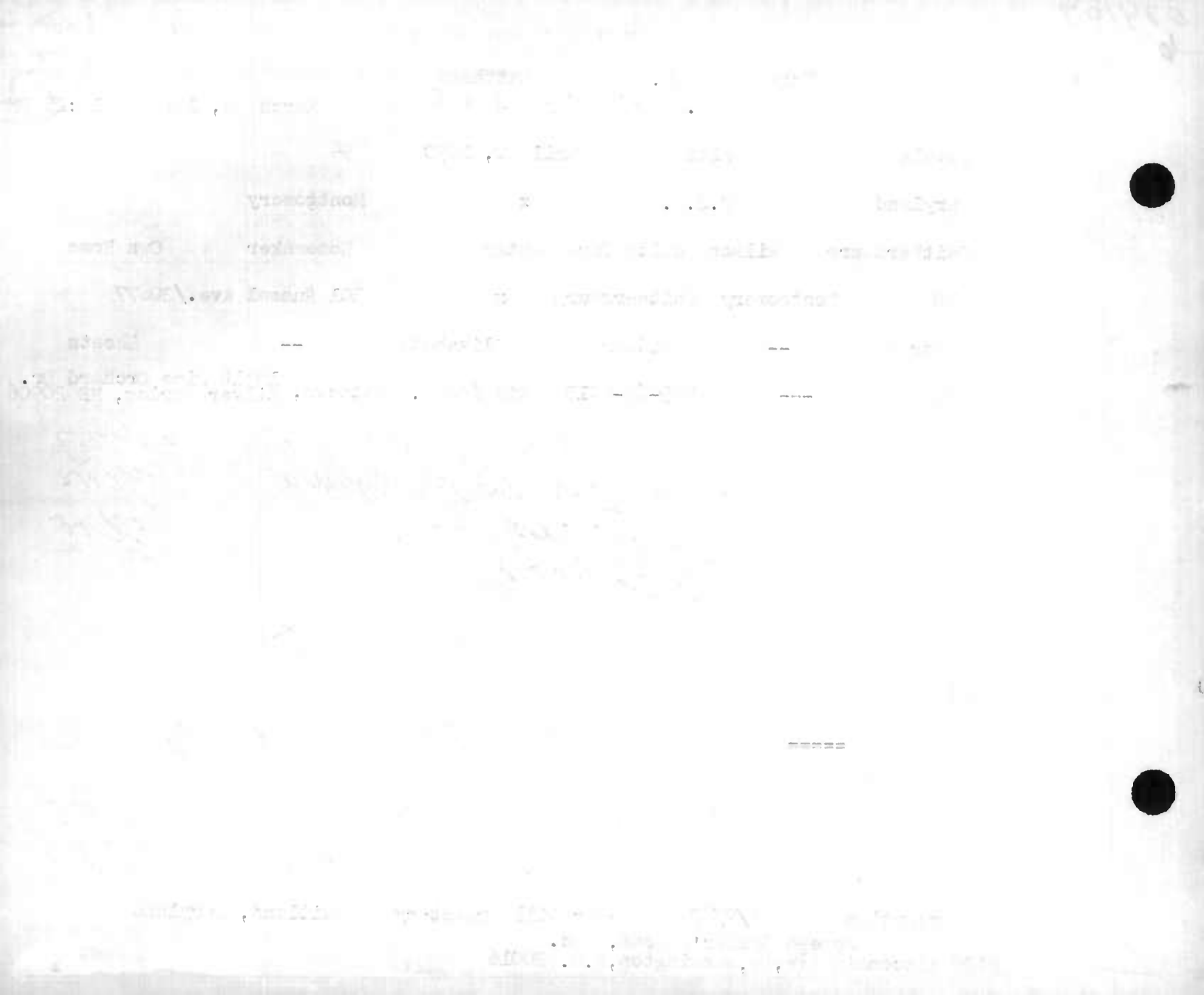
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 3 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Erma</u> MIDDLE <u>M.</u> LAST <u>Matthews</u> <u>ERMA M. MATTHEWS</u>		2. DATE OF DEATH MONTH DAY YEAR <u>March 5, 1985</u>	
3. SEX <u>Female</u>		4. RACE <u>White</u>	
5. DATE OF BIRTH MONTH DAY YEAR <u>April 30, 1890</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>94</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Gaithersburg</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Wilson Health Care Center</u>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. STATE <u>MD</u>		13b. COUNTY <u>Montgomery</u>	
13c. CITY OR TOWN <u>Gaithersburg</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <u>301 Russel Ave./20877</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Andrew -- Medders</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elizabeth -- Sheets</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>No ---</u>		16b. SOCIAL SECURITY NO. <u>579-62-8815</u>	
17. INFORMANT ADDRESS <u>William T. Matthews, 15316 Pine Orchard Dr., Silver Spring, MD 20906</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Intussusception</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intussusception</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (we) (hospital) attended the deceased from <u>Sept 80</u> to <u>date</u> , that (I) (we) (last saw the deceased alive on <u>2/28/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Thos G. Ward</u>		22c. ADDRESS <u>6116 Robinwood Bethesda, Md</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>3/7/85</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR NAME <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisconsin Ave, NW, Washington, D.C. 20016</u>		25. DATE RECEIVED BY REG. (PART 25) 26. PHYSICIAN'S SIGNATURE <u>MAR 11 1985</u> <u>Julia Davidson-Randall</u>	

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
1- STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Cyrus Haymond Maxwell Jr.			2a DATE OF DEATH MONTH DAY YEAR March 17, 1985			2b HOUR am 1:35 M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR June 6, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		12b KIND OF BUSINESS OR INDUSTRY U.S. Army	
13 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Montgomery Bethesda							
14 FATHER'S NAME FIRST MIDDLE LAST Cyrus Haymond Maxwell Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Melvina Adams		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			
16b SOCIAL SECURITY NO. WWI & WWII		17 INFORMANT (Wife)		ADDRESS 7211 Exfair Rd Bethesda, MD 20814			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)
Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Metastatic Carcinoma of Prostate

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 Days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Arteriosclerotic Heart Disease, Parkinsonism

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Feb 8, 1980, to March 9, 1985, that (I) (we) last saw the deceased alive on March 9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE John S. Saia MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 17, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Saia, MD		22e ADDRESS 809 Viers Mill Road, Rockville, MD 20851					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 21, 1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, MD		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 20 1985					

MEDICAL CERTIFICATION



WILLYS

100% COTTON

087054

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 3 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBYN DANIELLE MCCALLA			2a. DATE OF DEATH MONTH DAY YEAR MARCH 14 1985		2b. HOUR a.m. / p.m. 1:00 a
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR MARCH 1 1985		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 13	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND PRINCE GEO'S ANDREWS AFB			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT DUNKLEY MCCALLA			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST YOLANDA K. TRICE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS ROBERT D. MCCALLA, 4628-1 MAPLE COURT, ANDREWS AFB, MD 11203	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DISSEMINATED HERPES VIRUS SIMPLEX INFECTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 1 19 85 to MARCH 14 19 85 , that (I) (we) lost saw the deceased alive on MARCH 14 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Susan M. Galloway MD</i>		DEGREE MD		22c. DATE SIGNED 15 March 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. B. BOISVERT, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 18, 1985		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington, Virginia	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.		ADDRESS Old Alexander Ferry Road, Clinton, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 22 1985	
25b. REGISTRAR'S SIGNATURE <i>Carla Davidson-Randall</i>		25c. DATE MAR 22 1985			

MEDICAL CERTIFICATION

DHMH - 16 60M 7/84

(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, allows only injury, or other traumatic event, (accidental or otherwise) with a doctor's signature.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

20% COTTON - 80% POLYESTER

CHIEF MAN



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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) J. Howard McMillen		2a. DATE OF DEATH MONTH DAY YEAR 3-26-85		2b. HOUR 3 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 24, 1904	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENSINGTON GARDENS N.H.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
12a. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIST-NAT'L SCIENCE FOUNDATION		12b. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIST-NAT'L SCIENCE FOUNDATION		12c. USUAL OCCUPATION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIST-NAT'L SCIENCE FOUNDATION	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. STREET ADDRESS / ZIP CODE CHASE 4200 STANFORD ST. 20815	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY - McMILLEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA - OELSHLAGER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 216-44-3550		17. INFORMANT MARY A. McMILLEN (WIFE)		18. SEE ITEM # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) septic infection DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 21, 1982 to March 26, 1985 , that (I) (we) <input checked="" type="checkbox"/> saw the deceased on March 26, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					
22b. SIGNATURE Michael C. Chalasec		22c. DATE SIGNED 3/26/85		22d. PHYSICIAN'S NAME (TYPE OR PRINT) MALCOLM C. CHALASEC	
22e. ADDRESS 3720 FALLACUT AVE KENSINGTON, MD 20895		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22g. DATE SIGNED 3/26/85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 27 MAR 85		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.		23e. DATE REC'D. BY REGISTRAR APR 03 1985		23f. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 5 0 8 9 4 1

FOR
1- STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) Virgil VIRGIL		FIRST Virgil	MIDDLE NMI	LAST McComas	2a. DATE OF DEATH MONTH DAY YEAR 3-28-85	2b. HOUR 3:25 A.M.
3 SEX male	4. RACE White CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 11-4-1894		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH montgomery city. MD.		
10 CITY OR TOWN OF DEATH bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) suburban hospital		12a. USUAL OCCUPATION (IT: IF WORK FOR MOST OF WORKING LIFE) Breaking Codes		12b. KIND OF BUSINESS OR INDUSTRY War Dept. U.S. Gov't.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Cherry Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Burl Jackson McComas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Oceola Osborne				

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWF 220-44-2063	17 INFORMANT ADDRESS Roger Hingate, 4411 Everett St. Kensington
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Forward Heart Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) Mitral Regurgitation		11
DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured Chorda Tendinae		11

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION no		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) no		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO! WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 15, 19 85, to March 28, 19 85, that (I) (we) lost saw the deceased alive on March 27, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James F. McMurry Jr MD		DEGREE		22c. DATE SIGNED 3/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James F. McMurry Jr MD		22e. ADDRESS 6318 Democracy Blvd, Bethesda, MD		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/1/1985	23c. NAME OF CEMETERY OR CREMATORY Culpeper National Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Culpeper Virginia
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.		25. DATE REC'D BY REGISTRAR APR 02 1985	
26. ADDRESS 5130 Wisc. Ave., N.W. Wash. D.C.		27. REGISTRAR'S SIGNATURE John A. ...	

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Joseph Walter Jones

10. The following is a list of the names of the persons who have been appointed to the various committees of the Board of Directors of the American Telephone and Telegraph Company, for the year 1910:

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) GARNET D. McCOWN					2a. DATE OF DEATH MONTH DAY YEAR HOUR 03 15 85 235 A.M.				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 18 1916		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 710 ORCHARD WAY				12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF LIVING) PUBLIC SCHOOL SYSTEM		12b. KIND OF BUSINESS OR INDUSTRY PUBLIC	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 710 ORCHARD WAY 20904	
14. FATHER'S NAME FIRST LAST CECIL DAVIS		15. MOTHER'S MAIDEN NAME FIRST LAST VERA LINDER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 578-22-8136		17. INFORMANT Rebecca G. McCOWN, 710 ORCHARD WAY, SILVER SPRING, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC CIRRHOSIS DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC ACTIVE HEPATITIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/11 1985		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE 80 3/15 85					
22a. I certify that (I) (this hospital) attended the deceased from 3/13 1985 to 3/15 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mark H. Eig		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/15/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK H. EIG, M.D.		22e. ADDRESS 9801 GEORGIA AVE SILVER SPRING MD.							
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 3/15/1985		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION COUNTY STATE SUITLAND, PRINCE GEORGE'S MARYLAND			
24. DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25. DATE REC'D BY REGISTRAR MAR 18 1985		26. REGISTRAR'S SIGNATURE J. H. Davidson					

MEDICAL EXAMINER
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rose			2a. DATE OF DEATH MONTH 3 DAY 12 YEAR 85			2b. HOUR 1:05				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH JAN DAY 5 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13900 POND VIEW ROAD 20904	
14. FATHER'S NAME FIRST FRANCIS MIDDLE LAST MCCANN			15. MOTHER'S MAIDEN NAME FIRST THERESA MIDDLE LAST MCPHARLAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 187-36-9367		17. INFORMANT ADDRESS DOROTHY M. WERNER NIECE SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH None years "		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Alcoholism										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from 3/12/85 to date , 19 81 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death.										
22b. SIGNATURE Thos G. Ward			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 3/12/85		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD			22g. ADDRESS 6116 Robinson, Bethesda 20817							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MAR. 16, 1985		23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE PHILADELPHIA MONTGOMERY PENN.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.			25a. DATE REC'D. BY REGISTRAR MAR 18 1985			25b. REGISTRAR'S SIGNATURE John Davidson				

DIVISION OF VITAL RECORDS, 201 W. HESTON ST., BALTIMORE, MARYLAND 21201

Classified by *Medical Examiner's Office*

TO HOSPITAL OF ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "Lithograph" and "Lithography" are visible.]

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ABRAHAM LINCOLN MCGINLEY, III			2a. DATE OF DEATH MONTH DAY YEAR MARCH 13 1985		2b. HOUR 3:50 ^a _m
3 SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 5 1925		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
13a. STATE FLORIDA	13b. COUNTY MONROE	13c. CITY OR TOWN KEY WEST	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1415 PATRICIA STREET 33040	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM LINCOLN MCGINLEY, JR.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR COATES		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNK - 1967		17. INFORMANT ADDRESS VIVIAN C. MCGINLEY, 1415 PATRICIA STREET,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) WIDELY METASTATIC ADENOCARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 1 , 19 85 , to MARCH 13 , 19 85 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 13 , 19 85 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B. L. Flax</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED MARCH 14, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. L. FLAX, LT. MC. USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 16 Mar 85		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service, Falls Church, VA		24b. DATE REC'D. BY REGISTRAR MAR 21 1985		24c. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Francis H. McGrath			2a. DATE OF DEATH MONTH DAY YEAR March 6 185			2b. HOUR A. 4:10 M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 21 1897		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ins. Claims Mgr.		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 723 Regent Ct. (20878)	
14. FATHER'S NAME FIRST MIDDLE LAST Henry - McGrath			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 112-32-0121		17. INFORMANT Noreen McGrath ADDRESS 723 Regent Ct. Gaithersburg, Md. 20878					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent Renal Infection DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days years 6 mo		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease, CVA, & Chronic Asphyx										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from August 1975 to March 6, 1985 , that (I) (we) last saw the deceased alive on March 5, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Stuart A. Scott			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/6/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart A. Scott, M.D.			22e. ADDRESS Montgomery Village Ave., Gaith.Md. 20879							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/8/85		23c. NAME OF CEMETERY OR CREMATORY Long Island Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Long Island Suffolk N.Y.			
24. FUNERAL DIRECTOR Gartner Sandison F.H.			316 E. Diamond Ave., Gaithersburg, Md. 20877			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 08 1985 Julia Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 6 shows any injury, or other traumatic event, medical attention should be sought at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARY E. McGRATH				2a. DATE OF DEATH 26 6 1985 1:07 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10 26 1890	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD House Ret. & Nurs. Cen.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
13a. STATE DC		13b. COUNTY WASHINGTON		13c. CITY OR TOWN WASHINGTON	
14. FATHER'S NAME George		15. MOTHER'S MAIDEN NAME Mary E. Perrin		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-68 0861		17. INFORMANT Arthur Feenan ADDRESS 7109 OLIVER ST CHEVY CHASE MD	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ATRIAL FIBRILLATION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 25 6 1985 to 6 MARCH 1985 , that (I) (we) last saw the deceased alive on 4 MARCH 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James Mackin MD		DEGREE		22c. DATE SIGNED 6 MARCH 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES MACKIN MD		22e. ADDRESS 5401 WESTERN AVE WASHINGTON DC 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/9/1985		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc		25a. DATE RECD. BY REGISTRAR MAR 11 1985		25b. REGISTRAR'S SIGNATURE James Mackin	
26. ADDRESS 5130 Wisc. Ave., N.W. Wash., D.C.					

082158

2100 Pine Ave., N.W., Wash., D.C.

Joseph Taylor's Book Inc

Burill

3/9/1965

State of Nevada Cemetery

Silver Spring Maryland

man

Mary

John

House et. & N.W.

Gen.

Home

McNath

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM RAYMOND MESSMORE				2a. DATE OF DEATH MONTH DAY YEAR MARCH 2, 1985		2b. HOUR P M 4:30 P M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 28, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer-Wagner Casting Company		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE ILLINOIS		13b. COUNTY Macon		13c. CITY OR TOWN DECATUR		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Kirk Messmore		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosina Brown		13e. STREET ADDRESS / ZIP CODE 1155 VEECH LANE 62521			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES Yes WW II		16b. SOCIAL SECURITY NO. 330-18-7815		17. INFORMANT ADDRESS ANN E. RENNER (DAUGHTER) (SAME AS ABOVE)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable pneumonia/sepsis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several days	
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure						Weeks	
DUE TO, OR AS A CONSEQUENCE OF (c) Extensive metastatic melanoma in thorax, abdomen, skin						Year ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Multiple Myeloma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 28, 1984 , to March 2, 1985 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 2, 1985 , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE Mark A. Mazer		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/3/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK A. MAZER, MD		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 16, 1985		23c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Decatur, Illinois	
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes Arlington, Va. 22201				25. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 07 1985			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8508948

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CHARLES Louis Miller

2a. DATE OF DEATH MONTH DAY YEAR
3-13-85

2b. HOUR **2:35** P M

3. SEX **male**

4. RACE **white**

5. DATE OF BIRTH MONTH DAY YEAR
1-13-30

6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
55

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Massachusetts

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD.

10. CITY OR TOWN OF DEATH
Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Chief Res. Mgt.

12b. KIND OF BUSINESS OR INDUSTRY
N.O.A.A.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
Maryland Montgomery Silver Spring

13b. INSIDE CITY LIMITS? YES ☒ NO ☐

13c. STREET ADDRESS / ZIP CODE
809 Forest Glen Road (20901)

14. FATHER'S NAME FIRST MIDDLE LAST
Fred Miller

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lillian Kalman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes

16b. SOCIAL SECURITY NO.
Korean Conflict 031-22-9161

17. INFORMANT
Maryland 20901 Rosemary T. Miller; 809 Forest Glen Rd.; S. Spg

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Ventricular Fibrillation**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) **atherosclerotic cardiovascular disease**

(c) **5 minutes**

(b) **5 years**

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) **left ventricular aneurysm, severe coronary artery disease**

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **March 1984** to **March 13, 1985**, that (I) (we) last saw the deceased alive on **March 13, 1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE
Michael A. Lincoln M.D.

22c. DATE SIGNED
3/13/85

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael A. Lincoln M.D.

22e. ADDRESS
10313 Georgia Ave. Suite 308 Silver Spring Md 20902

23a. BURIAL, CREMATION, REMOVAL
Burial

23b. DATE
3/15/85

23c. NAME OF CEMETERY OR CREMATORY
Norbeck Memorial Gdns.

23d. LOCATION CITY OR TOWN COUNTY STATE
Olney; Montgomery; Maryland

24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 Rockville Pike; Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR
MAR 18 1985

25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
I. DECEASED NAME FIRST MIDDLE LAST HOMER R Miller				3-5-1985 7:15 ^{PM}			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 7-94		6. AGE (IN YEARS LAST BIRTHDAY) 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Dept of Justice	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William C. Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Unknown		13e. STREET ADDRESS 4807 Flanders Avenue 20895			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 1 216-44-4159		17. INFORMANT ADDRESS Mary J. Miller-Wife same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Urinary retention and uremia; diabetes mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>April 3-5 1965</u> to <u>3-5 1985</u> that (1) <u>was</u> lost saw the deceased alive on <u>3-5 1985</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>did</u> (did not) view the body after death.							
22b. SIGNATURE <u>Jason Reiger M.D.</u> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-5-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON REIGER, M.D.				22e. ADDRESS 8830 CAMERON ST. SILVER SPRING, Md. 20910			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Mar. 7, 1985		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.	
24. FUNERAL DIRECTOR Francis J. Collins 500 University Blvd. West Silver Spring, Md.				25. DATE REC'D BY REGISTRAR MAR 7 1985		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

500 University Blvd. West, Spring, W.
Francis J. Corbin
Mar. 7, 1985 Portland Corsetry

Portland, Oregon, W.



Yes CM 1 216-44-4150 Mary J. Miller, wife same as # 12

William C. Miller Frances

Washington Kensington 4877 Lincoln Avenue 20185

Dept of Justice

U.S.A.

NY

112-4-10-11

NY

NY

Frank

K

NY

8-2-10-1-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as such, it shows any injury, or other traumatic event, the medical examiner will be notified for an autopsy.

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3 4 85		2 45 PM	
Ruth		m		MILLER							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		CAUC		MONTH DAY YEAR		86 YRS.		MONTHS DAYS		HOURS MIN.	
11 16 98											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
CHILLUM		USA				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
WHEATON		UNIVERSITY CONV. - NURSING HOME		home maker Retired.							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS & ZIP CODE							
Maryland. Montg.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7051 Carroll Ave. 20912							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16a. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Stephen A. MIDDLE		Miller.		Adaline Soudner.		579-60-0142		Olivia Miller, 13821 Willoughby Rd.		Upper Marlboro Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		CVA		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(b)		ASCVD				48 hours	
				(c)						10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH		BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, SELECT MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>											
22a. I certify that (i) (this hospital) attended the deceased from 1/21/85, 19____, to 3/4/85, 19____, that (i) (we) last saw the deceased alive on 3/23/85, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) see the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
		Myron L. Lenkin		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3/4/85					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
MYRON L. LENKIN		2309 SHOREFIELD RD WHEATON, MD		Burial.		March 7, 1985		Rock Creek,		Washington, D.C.	
24a. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE		24d. DATE REC'D. BY REGISTRAR		24e. REGISTRAR'S SIGNATURE			
Takoma Funeral Home, Inc.		MAR 07 1985		John Davidson							
54 Carroll St. N. W. D. C.											



Continued on p. 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 5 1

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Myrtle A Milstead			2a DATE OF DEATH MONTH DAY YEAR March 11, 1985		2b HOUR 8:45P		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3 28 05		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST George W. Mills		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa V. Williams		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 577 09 9204	
17 INFORMANT Catherine Duvall (Sister)		17 ADDRESS 3902 Blackburn Lane S.S.Md.		17b. DATE SIGNED 20867		17c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 11, 1985 to March 11, 1985 , that (I) (we) last saw the deceased alive on March 11, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William W. Tullher, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/11/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William W. Tullher		22e. ADDRESS 11251 Lockwood Dr. S.S.Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/14/85		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Mont.Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi		11800 New Hamp. Ave. S.S.Md.		25. DATE REC'D. BY REGISTRAR MAR 15 1985		26. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transfer permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as illegal, it shows any injury, or other traumatic event, the medical officer or physician should be notified.

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NOV 1 1964



NOV 1 1964

Item #1, G-615, 5/1/86 by the
FOR
(Husband), Afvd., /Gbj.
REGISTRAR
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

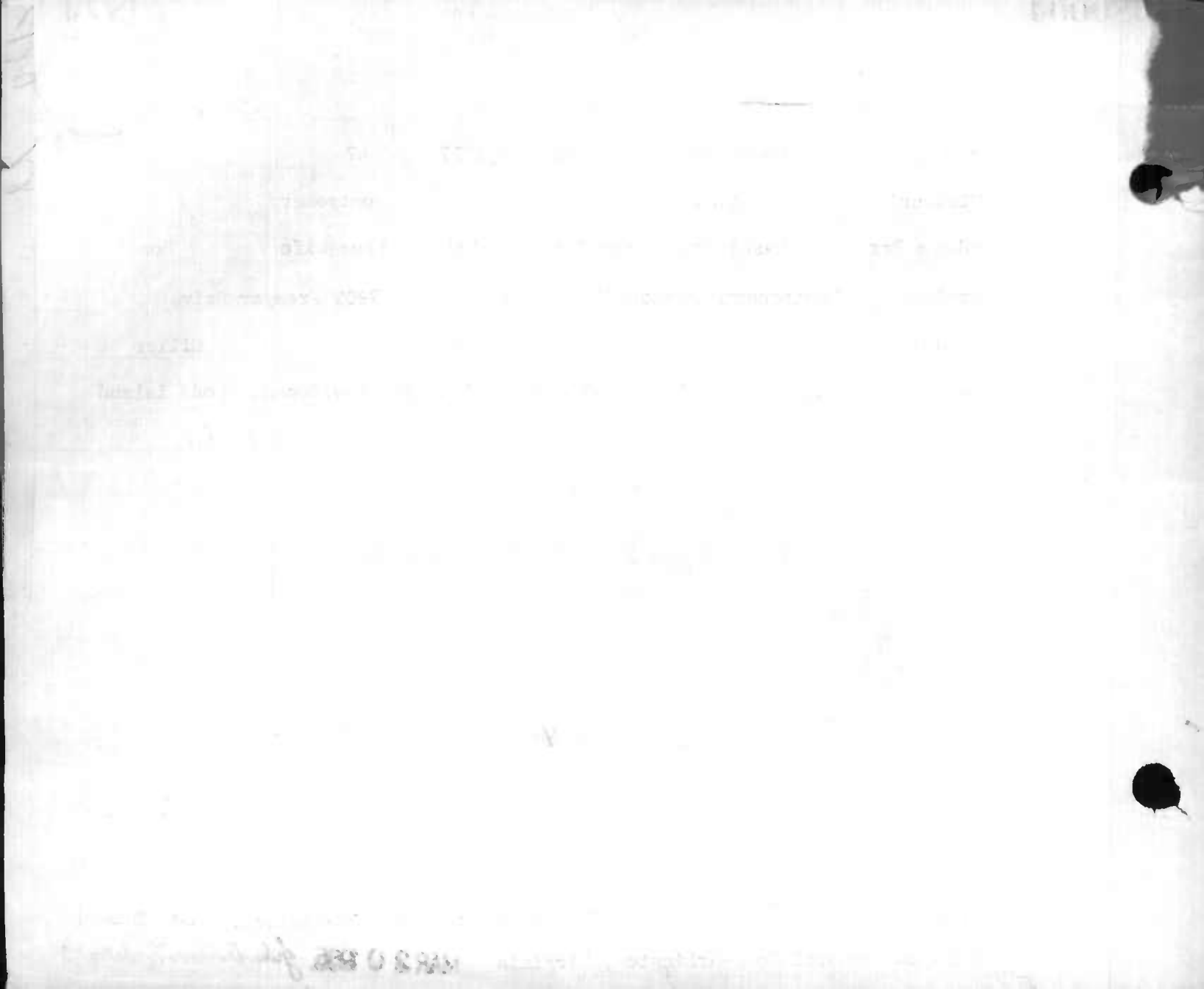
1. DECEASED NAME (TYPE OR PRINT) Elizabeth J. Mitchell			2a. DATE OF DEATH MONTH 3 DAY 6 YEAR 85			2b. HOUR M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH July DAY 20 YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7909 Kreegar Drive 20783	
14. FATHER'S NAME FIRST John MIDDLE Eli LAST Miller				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Miller LAST Miller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. n/a		17. INFORMANT John Mitchell-Providence, Rhode Island		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Acute Myocardial Infarction									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION 6		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 6				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER INST. BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 6 MONTH 6 DAY 19 YEAR 85 P.M. 6		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 6					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 6		21f. LOCATION STREET 6		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 3-4-85 19____ to 3-6-85 19____, that (I) (we) lost the deceased alive on 3-6-85 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles L. Franklin Jr				DEGREE MD				22c. DATE SIGNED 6-3-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Franklin Jr				22e. ADDRESS 11120 New Hampshire Ave S.W. Sp Md 20904					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-11-1985		23c. NAME OF CEMETERY OR CREMATORY North Burial Grounds		23d. LOCATION CITY OR TOWN Providence, Rhode Island COUNTY Providence STATE Rhode Island			
24. FUNERAL DIRECTOR NAME Arlington Funeral Home-Arlington, Virginia ADDRESS _____				25a. DATE REC'D. BY REGISTRAR MAR 20 1985 25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



092138

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE A LAST MITCHELL			2a DATE OF DEATH MONTH DAY YEAR 03 27 '85			2b HOUR 3:24 AM				
3 SEX F		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 03 11 1896		6 AGE (IN YEARS LAST BIRTHDAY) 89		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b KIND OF BUSINESS OR INDUSTRY NIH		
13a STATE MD		13b COUNTY Mont.		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 4502 Avamere St. 20814		
14 FATHER'S NAME FIRST RICHARD MIDDLE C. LAST PERRY		15. MOTHER'S MAIDEN NAME FIRST FANNIE MIDDLE S. LAST HERNDON		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 216 44 9369		17 INFORMANT Irene I Wine	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic organic brain syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (Name) attended the deceased from <u>23 Dec 1967</u> to <u>27 Mar 1985</u> , that (I) (we) last saw the deceased alive on <u>24 Mar 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE Horace W. Bernton				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 27 Mar. 85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Horace W. Bernton				22e. ADDRESS 4743 Bradley Blvd. Chevy Chase, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-28-85		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi				ADDRESS 11800 New Hamp Ave. S.S. Md		25a. DATE REC'D. BY REGISTRAR MAR 29 1985		25b. REGISTRAR'S SIGNATURE [Signature]		

BP

DECEMBER



ADULT MOTION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
STATE
REGISTRAR

REG. NO.

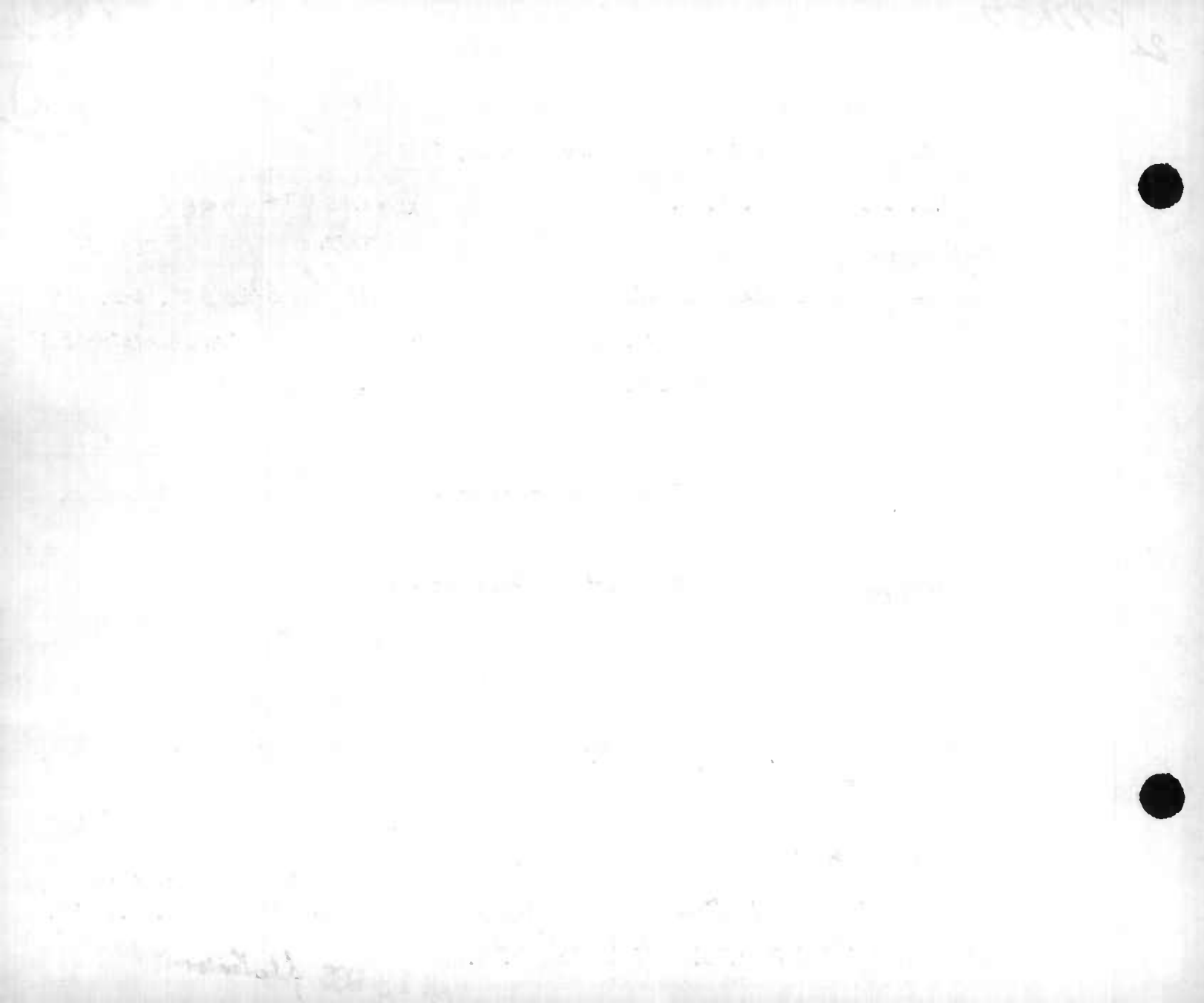
1. DECEASED NAME (TYPE OR PRINT) NAUM MITNIK			2a. DATE OF DEATH MONTH DAY YEAR 3-8-85			2b. HOUR 8:55 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 20, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.S.R.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SURBUEBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK AT MOST OF WORKING LIFE) Tailor		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 5715 CROSSFIELD Ct. Apt. # 9	
14. FATHER'S NAME FIRST MIDDLE LAST David Mitnik				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie (Unascertainable)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 214-90-8587		17. INFORMANT ADDRESS Ella Sirota (Same as # 13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH in meditate	
								7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Emphysema, Smoking, Transient ischemic attack.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) this hospital attended the deceased from July 13, 1978 to March 8, 1985 , that (I) we lost saw the deceased alive on March 8, 1985 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we and (did not) view the body after death.									
22b. SIGNATURE Sidney S. Cohen					DEGREE M.D.			22c. DATE SIGNED Mar. 9, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney S. Cohen, M.D.					22e. ADDRESS 121 Congressional Lane, Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/10/1985		23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon		23d. LOCATION Hyattsville, P. G., Md.		
24. FUNERAL DIRECTOR P. M. STEIN, HEB. MEM. FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR Mar 13 1985				
25b. REGISTRAR'S SIGNATURE [Signature]									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes", a copy of this certificate must be filed with the medical examiner.



081144

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8955

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anthony — Monaldo			2a. DATE OF DEATH MONTH DAY YEAR March 13, 1985			2b. HOUR 6:58 PM					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 9, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 75			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CABINET MAKER		12b. KIND OF BUSINESS OR INDUSTRY CARPENTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 10504 GRANDIN ROAD / 20902			14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH — MONALDO			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA — STILLITANO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 579-01-6033			17. INFORMANT ADDRESS PATRICK MAIOLLO (NEPHEW) SAME AS #13.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

hypotension

DUE TO, OR AS A CONSEQUENCE OF

(b) **Infected Intestine**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Strangulation Internal Hernias**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 3/2/85 3/4/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated Strangulation Hernias		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Eric A. Cristian		DEGREE MD		22c. DATE SIGNED 3/14/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric A. Cristian MD		22e. ADDRESS 344 University Blvd W. Silver Spring Md		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 16/85		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG.CO. MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS CHAMBERS FUNERAL HOME SILVER SPRING, MD.				25a. DATE REC'D. BY REGISTRAR MAR 20 1985		25b. REGISTRAR'S SIGNATURE	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1- STATE REGISTRAR										08950	
1. DECEASED NAME (TYPE OR PRINT) Jacque C. Morrell										2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 20 85	
3. SEX male 4. RACE white 5. DATE OF BIRTH MONTH DAY YEAR 1 18 93 6. AGE (IN YEARS) LAST BIRTHDAY 92 YRS. 7. DATE OF BIRTH MONTH DAY YEAR 1 18 93 8. AGE (IN YEARS) LAST BIRTHDAY 92 YRS. 9. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 10. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.										2b. DATE PRONOUNCED DEAD 3 20 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Retirement & Nursing Cen. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist 12b. KIND OF BUSINESS OR INDUSTRY Chemistry											
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY Washington 13c. CITY OR TOWN Washington 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 4501 Conn. Ave., N.W. 20008											
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Morrell 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWI & WWII 16b. SOCIAL SECURITY NO. 324-18-9046 17. INFORMANT ADDRESS Mildred Morrell. Same as item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) coronary arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). alzheimer's disease.											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE John Tanber TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE 3-20-85											
EXAMINER'S NAME (TYPE OR PRINT) John Tanber ADDRESS 8218 Wisconsin Ave											
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial 23b. DATE 3/26/1985 23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. 23d. LOCATION Arlington Virginia STATE											
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 25a. DATE REC'D. BY REGISTRAR MAR 28 1985 25b. REGISTRAR'S SIGNATURE John Davidson-Rodgers											

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Yes I am a member of the following organizations:

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove containers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Grace</u> <u>MULLEN</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>3/5/85</u>		2b. HOUR <u>10:30 AM</u>	
3. SEX <u>FEMALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>11</u> <u>22</u> <u>1906</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pa.</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD		
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>COOK</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	
13a. STATE <u>MD.</u>			13b. COUNTY <u>MONTGOMERY</u>	13c. CITY OR TOWN <u>SILVER SPRING</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>MATTHIAS K. BEER</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>MAGGIE BELLE LUCAS</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>211-03-1732A</u>		17. INFORMANT ADDRESS <u>GRACE C. MAIOLLO 2905 BURTON HILL DR KENSINGTON, MD. 20895</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ALZHEIMER'S DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>OCT 19 84</u> to <u>5 MAR 19 85</u> , that (I) (we) last saw the deceased alive on <u>4 MAR 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) last did not view the body after death.						
22b. SIGNATURE <u>Walter E. Goetz MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5 Mar 85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WALTER E. GOETZ MD</u>				22e. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u>		
23a. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>BURIAL</u>		23b. DATE <u>3-8-1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEM.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>SILVER SPRING Montg. Md.</u>
24. FUNERAL DIRECTOR NAME <u>W.W. CHAMBERS CO INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAR 7 1985</u>
25b. REGISTRAR'S SIGNATURE <u>Wm. Davidson-Randall</u>						

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Patrick J Mulligan			2a. DATE OF DEATH MONTH DAY YEAR 3-8-85		2b. HOUR 0025 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1947	6. AGE (IN YEARS LAST BIRTHDAY) 37	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Officer Dept.	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Poolesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 17104 Hughes Road 20837	
14. FATHER'S NAME FIRST MIDDLE LAST Ernest H. Mulligan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elda Nagel			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-54-7021		17. INFORMANT Wife ADDRESS Christine Mulligan Same as item 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **FIBROSIS OF LUNG**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) **BLEOMYCIN CHEMOTHERAPY**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

TESTICULAR CARCINOMA

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/17 , 19 85 , to 3/7 , 19 85 , that (I) (we) last saw the deceased alive on 3/7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Alan S. Chanales		DEGREE M.D.		22c. DATE SIGNED 3/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN S. CHANALES		22e. ADDRESS 1410 OLD GEORGETOWN RD, BETHESDA			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11, 1985	23c. NAME OF CEMETERY OR CREMATORY Darnestown Presbyterian Darnestown, Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR MAR 13 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Page 1

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Page 3 of 3

Page 4 of 4

Page 5 of 5

Page 6 of 6

Page 7 of 7

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with a 22-hour death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SALLIE LUCILLE MURPHY			2a. DATE OF DEATH MONTH DAY YEAR MARCH 18 1985		2b. HOUR AM PM 8:17 A		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOVEMBER 15 1894		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) ARKANSAS		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE DISTRICT OF COLUMBIA		13b. COUNTY DC		13c. CITY OR TOWN WASHINGTON, DC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SIMEON T. LEWIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE REBECCA MCCURDY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IE YES, GIVE WAR OR DATES) 577-84-4957	
17. INFORMANT ADDRESS NELL E. MACCRACKEN, 2933 BENTON PLACE, NW		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		WASHINGTON, DC 20008		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from JANUARY 16 , 19 85 , to MARCH 18 , 19 85 , that (I) (we) lost saw the deceased alive on MARCH 18 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J B Hermler</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 19 Mar 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. B. HERMILLER, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/21/1985		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>W. Davidson-Hendall</i>	

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LIBRARY COLLECTION

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210 Rec. v. 1.
Journal Editor, Inc.
3/1/1985
Oak Creek Cemetery
Washington, D.C.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST SIDNEY MIDDLE FORREST LAST MUSSELMAN SIDNEY FORREST MUSSELMAN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 3 22 19 85			2b. HOUR 1900								
1. SEX M		4. RACE CAUC		5. DATE OF BIRTH MONTH 4 DAY 8 YEAR 10		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH 3 DAY 22 YEAR 19 85		2d. HOUR 1900		
3. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
11. CITY OR TOWN OF DEATH CHEVY CHASE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5522 TRENT ST						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECH ENG			12b. KIND OF BUSINESS OR INDUSTRY NASA		
13a. STATE MD			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN CHEVY CHASE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5522 TRENT ST		
14. FATHER'S NAME FIRST SIDNEY MIDDLE FORREST LAST MUSSELMAN						15. MOTHER'S MAIDEN NAME FIRST IDA MIDDLE REMINGTON LAST REMINGTON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. (IF YES, GIVE WAR OR DATES) WW II			17. SOCIAL SECURITY NO. 234-01-3552			17. INFORMANT (NAME AND ADDRESS) (DAUGHTER) BREEZY PT., QUEENS, N.Y. JANET GAIL DEVER, 4 BEACH 209TH ST, 11697					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ALIVE YES														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 7 A.M. 3 P.M. MONTH 3 DAY 22 YEAR 19 85				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) DIED IN BED						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET STRENT ST CITY OR TOWN CHEVY CHASE COUNTY MONTGOMERY STATE MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE Francis C. Mayer				TITLE (SPECIFY) DEPT				DATE SIGNED 3/22/85						
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayer				ADDRESS 8200 Wisconsin Ave Bethesda MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 3/23/85		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY				23d. LOCATION CITY OR TOWN ALEXANDRIA COUNTY PG. STATE MD.				
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. ADDRESS 1804 T ST., N.W., WASH., D.C., 20009						25a. DATE REC'D. BY REGISTRAR MAR 27 1985		25b. REGISTRAR'S SIGNATURE John W. Decker - Registrar						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITHIN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MYER R. MUSSER			2a. DATE OF DEATH MONTH DAY YEAR 3 - 19-85		2b. HOUR 8:45 pm		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 9, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL LUTHERAN HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STORE MANAGER		12b. KIND OF BUSINESS OR INDUSTRY NOT AVAILABLE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 6216 FAIRDEL AVENUE		13f. ZIP CODE 21206		13g. STREET ADDRESS / ZIP CODE 6216 FAIRDEL AVENUE		13h. ZIP CODE 21206	

14. FATHER'S NAME FIRST MIDDLE LAST MELANTHON MUSSER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL --- MUSSER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 178-10-9068	
17. INFORMANT REV. DR. RICHARD REICHARD		18. ADDRESS N.L.H. - ROCKVILLE	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure; Parkinson's disease			
19a. DATE OF OPERATION March 19, 1985		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Parkinson's disease	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Nov 11, 1983 to March 19, 1985 , that (I) (we) last saw the deceased alive on March 19, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Harold F.M. Cann M.D.		22c. DATE SIGNED 3-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD F.M. CANN		22e. ADDRESS 3355-16th St N.W. WASH DC.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 25, 1985		23c. NAME OF CEMETERY OR CREMATORY GARDEN OF FAITH CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR NAME HYSONG CO., INC. - 1300-N STREET, NW WASH., DC				25a. DATE REC'D. BY REGISTRAR APR 02 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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086093

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

| | | | | | |
|--|--|---|--|---|---|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| I. DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) | | March 21, 1985 | | 8:40pm | |
| Katharine V. Nally | | | | | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| Female | Caucasian | April 8, 1894 | 90 YRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH | | |
| New York | United States | | Montgomery County, MD. | | |
| 10 CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Bethesda | 4508 Cheltenham Drive | | Tax Attorney | | U.S. Gov't. |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | Montgomery | Bethesda | 4508 Cheltenham Drive 20814 | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | |
| Michael Nally | | | Katharine Burk | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | 17 INFORMANT ADDRESS | | |
| No | | 220 44 0483 | Niece 4514 Chestnut Street Virginia D. Fisher Bethesda, Maryland 20814 | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> | | | | | 3 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Cardio-Vascular Nephrosclerosis</u> | | | | | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>10</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from June 9, 1966, to March 19, 1985, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE DOCTOR | | | | 22c. DATE SIGNED | |
| Robert C. Haile MD | | | | March 22, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | |
| Robert C. Haile, M.D. | | | 5100 Wisconsin Avenue N.W. #405 Washington, D.C. 20016 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| Burial | | March 27, 1985 | St. Peters Cemetery | Troy New York | |
| 24 FUNERAL DIRECTOR NAME | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland 20814 | | | MAR 26 1985 [Signature] | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20% COTTON FIBER

WHEATON ROAD



086092

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR pm | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Florence D. Needham | | | | March 21, 1985 | | | | 5:13 M | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
December 15, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
92 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Michigan | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County Maryland | | | |
| 10. CITY OR TOWN OF DEATH
Chevy Chase | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bethesda Retirement & Nursing Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Frank Duval | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
579-56-7365 | | 17. INFORMANT ADDRESS
Nancy N. Goodrich (Daughter) 6003 Corbin Road Bethesda, Maryland 20816 | | | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Intractable Heart Failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 Mos |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 10/21, 1978, to 3/21, 1985, that (1) was lost above the deceased alive on 3/20, 1985, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. | | | | | | | |

| | | | | | |
|---|--|---|--|------------------------------------|--|
| 22a. SIGNATURE OF PHYSICIAN
J. Blaine Fitzgerald, MD | | 22b. ADDRESS
8218 Wisconsin Avenue, Bethesda, Maryland | | 22c. DATE SIGNED
March 22, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Blaine Fitzgerald, MD | | 22e. ADDRESS
8218 Wisconsin Avenue, Bethesda, Maryland | | | |

| | | | | | | | |
|--|--|-----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
March 22, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Alexandria, Virginia | |
| 24. FUNERAL DIRECTOR NAME
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1985 | | 25b. REGISTRAR'S SIGNATURE
June Davidson-Rendall | |

RECEIVED
11/17/01

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SADIE L. NEEDHAM | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 8, 1985 | | | 2b. HOUR
2:35A | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN. 4 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | 6. UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
81 | |
| 7a. BIRTHPLACE
STATE OR FOREIGN COUNTRY
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Washington | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House keeper | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE
D.C. | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dock Needham | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adelaide Hyman | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | |
| 16b. SOCIAL SECURITY NO.
587-26-7705 | | | 17. INFORMANT
William Needham/1650 Newton Street N.W. | | | ADDRESS Washington, D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Coronary shock
DUE TO, OR AS A CONSEQUENCE (b) Acute Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery atherosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
Hours | |
| | | | | | | | | Days | |
| | | | | | | | | Years | |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec 28 , 19 84 , to March 8 , 19 85 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on March 8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
H. S. Segal MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
March 9, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. S. Segal MD | | | | 22e. ADDRESS
6513 Gooch Rd
Silver Spring Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-12-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Marshall's Funeral Home
4217 9th St NW: Washington, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 14 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rendall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85

0 8965

1. FOR
STATE
REGISTRAR

093140

| | | | | | | | | | | |
|---|--|---|---|---|--|--|---|--|---|--|
| 2a. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Lina Marie Nestler</u> | | | 2b. DATE OF DEATH
MONTH DAY YEAR
<u>March 29, 1985</u> | | | 2c. HOUR
<u>6:15</u> A M | | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>Sept. 15 1885</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>99</u> YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Germany</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>University Nursing Home</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>Maryland</u> | | | 13b. COUNTY
<u>Montgomery</u> | | 13c. CITY OR TOWN
<u>Silver Spring</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<u>9013 Colesville Road 20910</u> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Henry Schulz</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Anna Wallbrecht</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>No</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>235-84-9368</u> | | 17. INFORMANT
<u>Hans W. Nestler</u> | | ADDRESS
<u>Son Same as 13</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>inanition</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, general 7 years</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 months</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1976</u> , to <u>3-29-85</u> , that (I) (we) last saw the deceased alive on <u>3-21-85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>James Reiger, MD</u> | | | | | | DEGREE
<u>MD</u> | | 22c. DATE SIGNED
<u>3-29-85</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JAMES REIGER, MD</u> | | | | | | 22e. ADDRESS
<u>PP 30 CAMERON STREET SILVER SPRING, MD. 20910</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<u>BURIAL</u> | | | 23b. DATE
<u>4/2/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>MOUNT OLIVET CEMETERY</u> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>PARKERSBURG WOOD WEST VIRGINIA</u> | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u> | | | | | | 25. APR 1 1985 | | 26. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01220

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 7 6 6

FOR
1. STATE
REGISTRAR

REG. NO.

093149

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DORIS JEAN NICELY | | | 2a. DATE OF DEATH
MONTH 3 DAY 30 YEAR 85 | | 2b. HOUR
6⁰⁰ a.m. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
April 20th 1928 | 6. AGE (IN YEARS LAST BIRTHDAY)
56 | 7. IF UNDER 1 YEAR
MONTHS YRS. DAYS HRS. MIN. | |
| 7a. BIRTHPLACE
Washington, DC | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
Postal worker | 12b. KIND OF BUSINESS OR INDUSTRY
Post Office | |
| 13. USUAL RESIDENCE (IF MARKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY P.G. 13c. CITY OR TOWN Hyattsville | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST Walter MIDDLE Vermillion LAST French | | | 15. MOTHER'S MAIDEN NAME
FIRST Helen MIDDLE French LAST French | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
579-38-4602 | | |
| 17. INFORMANT
Grover A. Nicely (Husband) | | | ADDRESS
Same as 13c | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*respiratory failure*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH*1h*

DUE TO, OR AS A CONSEQUENCE OF

(b)

*metastatic woman cancer**1h*

DUE TO, OR AS A CONSEQUENCE OF

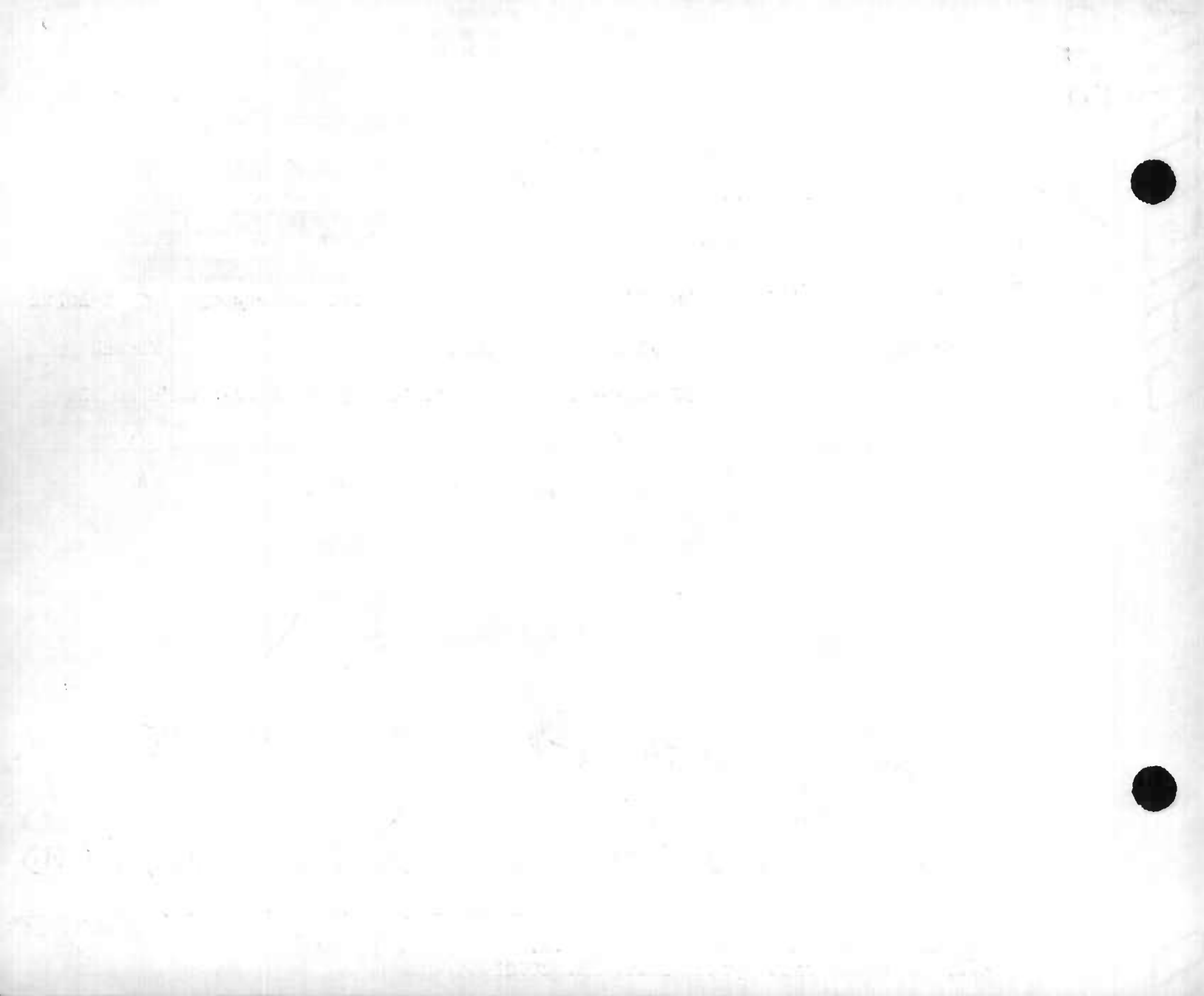
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 29 85 to Mar 85 , that (I) (we) lost
saw the deceased alive on Mar 29 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Martin D. Wertz | | 22c. ADDRESS
7525 Greenway Center Drive Glenelg MD | 22d. DATE SIGNED
3/20/85 |

| | | | |
|---|----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
4/2/85 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION
CITY OR TOWN Suitland COUNTY P.G. STATE Maryland |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave. Hyattsville, Md. 20781 | | | 25a. DATE REC'D. BY REGISTRAR
APR 1 - 1985 |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon #2. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | | | |
|--|---|--|---|--|---|---|--|--|---------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) Warren W NICHOLAS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 11 85 | | | | 2b. HOUR
3:05AM |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 11 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Iowa | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Physicist-Chemist | | 12b. KIND OF BUSINESS OR INDUSTRY
Shell Oil Co. | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Bethesda | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
5415 Bradley Boulevard 20814 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Walter Nicholas | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Brandt | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
069-01-5131 | | 17. INFORMANT
ADDRESS
Elizabeth P. Nicholas Bethesda, Maryland 20814 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Acute Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/10 1985 to 3/11 1985 , that (I) was last saw the deceased alive on 3/10 1985 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Carol Bender | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/11/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carol Bender | | | | 22e. ADDRESS
11510 Old Georgetown Rd., Rockville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
March 11 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Geo. Wash. Med. Sch. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR
MAR 16 1985 | | | | | |

1900

1900

1900

092039

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 6 8

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES FREDERICK NORMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 23 1985 | | 2b. HOUR
6:25 a.m. |
| 3. SEX
MALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 21 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. ARMY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
NEW JERSEY | | | 13b. COUNTY
CAMDEN | 13c. CITY OR TOWN
GLOUCESTER CITY | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM FRANCIS NORMAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
KATHERINE MARIE EYDLER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1963 179-07-2271 | | 17. INFORMANT
ADDRESS
THOMAS L. NORMAN, 124 LAMBERT AVE., GLOUCESTER CITY, NJ 08030 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLISM
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

| | | | |
|--|--|--|---|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
ATHEROSCLEROTIC VASCULAR DISEASE | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 21 , 19 85 , to MARCH 23 , 19 85 , that (I) (we) lost
saw the deceased alive on MARCH 23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
W. A. DELACEY
22b. PHYSICIAN'S NAME (TYPE OR PRINT)
W. A. DELACEY, LT, MC, USNR | | 22c. DATE SIGNED
25 MAR 85
22c. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,
NATIONAL CAPITAL REGION, BETHESDA MD 20814 | |

| | | | |
|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
1985 MARCH 28 | 23c. NAME OF CEMETERY OR CREMATORY
MT GREENWOOD CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SHAVERTOWN LUZERNE CO PENNSYLVANIA |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL
HOMES, P.A. BETHESDA, MARYLAND | | 25a. DATE REC'D BY REGISTRAR
MAR 28 1985 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |

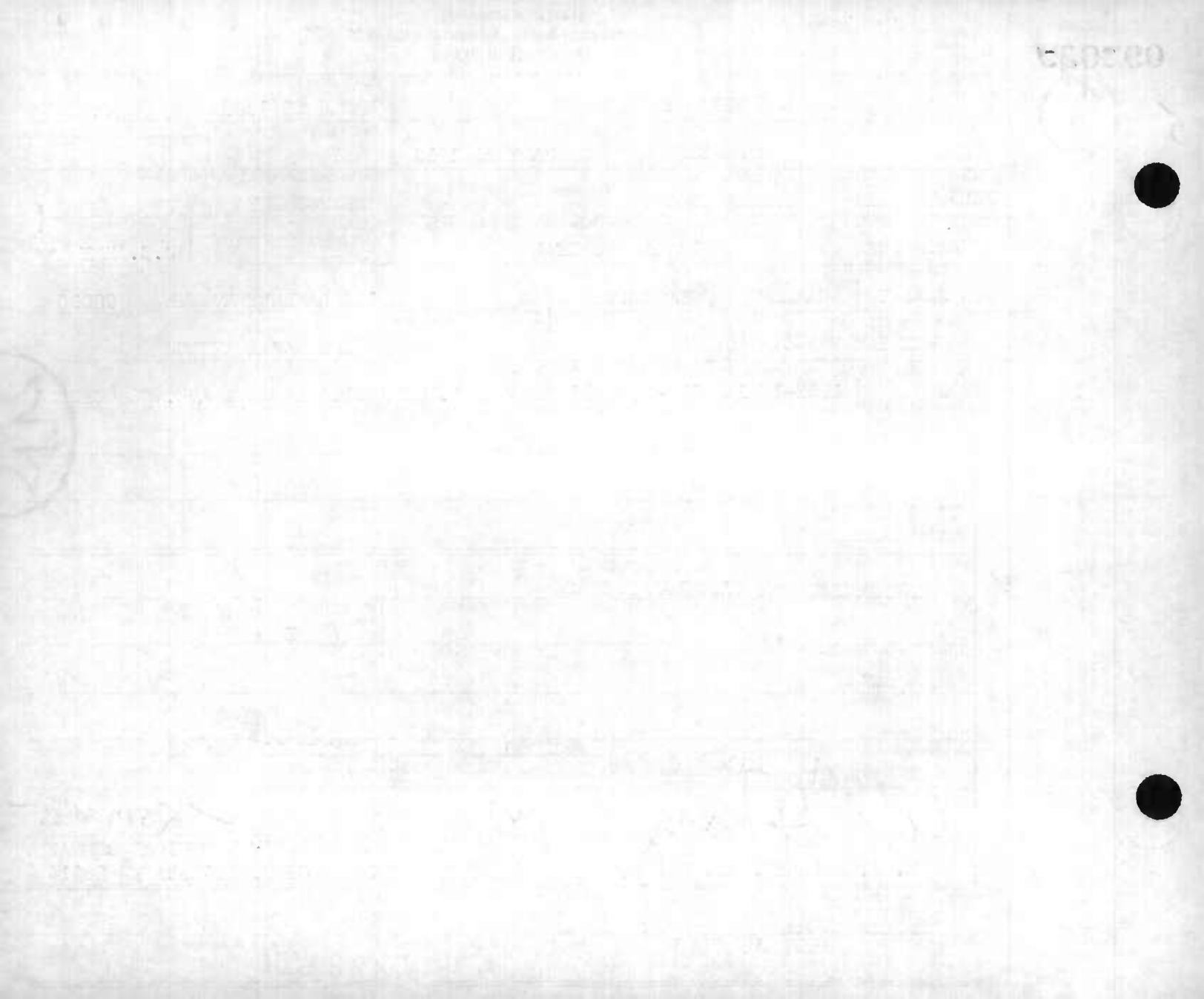
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is in any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Eugene E. Norris | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-26-85 | | 2b. HOUR
1258 M |
| 3. SEX
male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
2-27-06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Herman Wilson Health Care Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY
auto | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Gaithersburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
301 Russell Ave. 20760 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene L. Norris | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Corine Sanders | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
578-03-5880 | | 17. INFORMANT
ADDRESS
Thomas B. Norris 8503 Rose Marie Dr. Ft. Wash Md. | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular irritability with arrhythmia | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
4 min |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | 5 yrs. |
| (b) Arteriosclerotic heart disease | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (b)
Chronic respiratory failure, due to COPD. Congestive heart failure

| | | | |
|--|--|---|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) this hospital attended the deceased from Aug 13 19 80 to March 26 19 85 , that (I) (we) last saw the deceased alive on March 25 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
James R. Moore Jr. | DEGREE
MD | 22c. DATE SIGNED
3-26-85 | |
| 22d. ADDRESS
207 Brookes Ave Gaithersburg Md. | | | |

| | | | |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/28/85 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland P.G. Md. |
|---|-----------------------------|--|--|

| | | |
|---|---|--|
| 24. FUNERAL DIRECTOR
NAME
G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md. | 25a. DATE REC'D. BY REGISTRAR
MAR 29 1985 | 25b. REGISTRAR'S SIGNATURE
La. Swindon-Randall |
|---|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the health officer after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GERTRUDE LOUISE NOVOSEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 30 1985 | | 2b. HOUR
P M
9:39 P |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 16 1936 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEBRASKA | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VIRGINIA | | | 13b. COUNTY
PRINCE WM. | 13c. CITY OR TOWN
WOODBIDGE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JAMES HERRINGTON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ESTHER MORRISON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
478-36-7902 | | 17. INFORMANT
ADDRESS
JOHN J. NOVOSEL, JR., 12311 HARBOR DRIVE, WOODBRIDGE, VA 22192 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA OF LUNG
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 30 , 19 85 , to MARCH 30 , 19 85 , that (I) (we) last saw the deceased alive on MARCH 30 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
1 APR 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H.P. LIEBERT, LT, MC, USNR | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
4/03/85 | 23c. NAME OF CEMETERY OR CREMATORY
Quantico Ntl. Cem. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Triangle Pr. William VA | | |
| 24. FUNERAL DIRECTOR
Cunningham-Mountcastle F.H. | | ADDRESS
13318 Occoquan Woodbridge, VA | 25a. DATE REC'D. BY REGISTRAR
APR 5 1985 | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed in the funeral director's office.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|---|---|
| 1. DECEASED NAME
(LAST, FIRST, MIDDLE)
DELMAS H. NUCKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 26 85 | | | 2b. HOUR
MIN.
10 47 AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Apr. 12 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Indiana | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3527 S. Leisure World Blvd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Manager Salesman | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Mobil Oil Co. | | | | | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13. STREET ADDRESS / ZIP CODE
3527 S. Leisure World Blvd 55md20706 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Henry Nucker | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Isabel Oats | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
Catherine M. Nucker-wife-(same as 13e) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF:
(b) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF:
(c) Ventricular Arrhythmia | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 years
3 yrs
2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13/85 to 3/26/85 , that (I) (we) last saw the deceased alive on 2/13/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donal G. Giddens | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/26/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR SIGN) | | 22e. ADDRESS
3701 Banner Blvd. Silver Spring, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
Mar. 27, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 29 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - not 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08972

| | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST NATHAN | | MIDDLE | | LAST OBENG | | 2a. DATE KNOWN
OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 8. IF UNDER 24 HRS. | | 9. DATE PRONOUNCED
DEAD | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 12b. KIND OF BUSINESS
OR INDUSTRY | | 12c. SCHOOL | |
| 14. FATHER'S NAME | | FIRST Seth | | MIDDLE Hnnua | | LAST Obeng | | 15. MOTHER'S MAIDEN NAME | | FIRST Catherine | | MIDDLE Eloise | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 17a. ADDRESS | | 17b. Brother | | 17c. 19205 Coley Street | | 17d. Detroit, Mich. 48219 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Fell from balcony | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): | | None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET | | 21g. CITY OR TOWN | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | death resulted from: | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY) | | M.D. | | MEDICAL EXAMINER | | DATE
SIGNED | | 11-2-85 | | 23/85 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | John S. Rogers, DME | | ADDRESS | | 1919 Seminary Road, Sil. Spr. M d. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN | | COUNTY | | STATE | | | |
| Burial | | Mar. 30, 1985 | | Woodlawn Cemetery | | Detroit | | | | Michigan | | | |
| 24. FUNERAL DIRECTOR
NAME | | Hines/Rinaldi Funeral Home | | ADDRESS | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | MAR 26 1985 | |

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Lillian M O'Connor | | | 2a. DATE OF DEATH
MONTH DAY YEAR 03 04 85 | | | 2b. HOUR
1:40 PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR 10 15 19 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(NOT IN SUCH CITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Electronics Assembler MicroDyne | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Agnello | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Josephine Oliveri | | 13e. STREET ADDRESS / ZIP CODE
11809 College View Dr, 20943 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
200-05-4136 | | 17. INFORMANT
J. Joseph O'Connor ADDRESS
10276 Wayover Way Columbia Md. 21046 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b) IRREVERSIBLE HYPOXIA 1 WK
DUE TO, OR AS A CONSEQUENCE OF (c) END STAGE EMPHYSEMA + COPD YRS. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/1 , 19 60 , to 3/4 , 19 85 , that (I) (we) last saw the deceased alive on 3/4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Richard P. Delaney, MD DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD P. DELANEY MD | | | | 22e. ADDRESS
4323 HARVARD ST SIL. SPRG, MD 20906 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar. 7, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS 500 UNIVERSITY BLVD. WEST, SILVER SPRING MD 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 7 1985 | | 25b. REGISTRAR'S SIGNATURE
John Burdick-Randall | |

BP

52

092129

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|--|--|---|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
THOMAS DANIEL O'KEEFE | | | 2a DATE OF DEATH
MONTH DAY YEAR
MARCH 22 1985 | | 2b HOUR
10:30P M |
| 3 SEX
MALE | 4 RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
AUG 04 01 | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MASSACHUSETTS | 7b CITIZEN OF WHAT COUNTRY?
USA | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10 CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED Officer | | 12b. KIND OF BUSINESS OR INDUSTRY
NAVY |
| 13a. STATE
VIRGINIA | | | 13b. COUNTY
FAIRFAX | 13c. CITY OR TOWN
MCLEAN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
THOMAS DANIEL O'KEEFE | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET NMN CONWAY | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1918-1960 | 17. INFORMANT
6251 OLD DOMINION DR. 376
DICIE O'KEEFE MCLEAN, VIRGINIA 22101 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK
DUE TO, OR AS A CONSEQUENCE OF
(b) MALIGNANT HISTIOCYTOSIS
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAR 10 19 85 to MAR 22 19 85, that (I) (we) last saw the deceased alive on MAR 22 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | |
| 22b SIGNATURE
William A. Delacey | | DEGREE
MD | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
25 MAR 85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
W. A. DELACEY, LT, MC, USNR | | 22e ADDRESS
NAVAL HOSPITAL BETHESDA, NMCNCR, BETHESDA, MD 20814 | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b DATE
3/26/85 | 23c NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | 23d LOCATION
Suitland, MD COUNTY STATE | | |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.
NAME ADDRESS
5130 WI Ave. N.W. Wash., DC | | | 25a. DATE RECD. BY REGISTRAR
MAR 29 1985 | | |

11420

Office

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

081973

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|---|---|--|---|---|-------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Cornelius O'Leary</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <i>2-12-85</i> | | 2b. HOUR
<i>4:11AM</i> | | | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>10-18-97</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>87</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>VIRGINIA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spring</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>St. Mary's Cross Hospital</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>RETIRED</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>UNAVAILABLE</i> | | | |
| 13a. STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>MONTGOMEY</i> | | 13c. CITY OR TOWN
<i>UNAVAILABLE</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>UNAVAILABLE 20879</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>UNAVAILABLE</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>UNAVAILABLE</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>YES</i> | | | | 16b. SOCIAL SECURITY NO.
<i>718-18-8480</i> | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Ascrob, dehydration, sepsis, renal failure</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> RESTING <input type="checkbox"/> OTHER <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>2/12/85</i> to <i>2/12/85</i> that (1) last saw the deceased alive on <i>2/12/85</i> and that (2) our opinion death occurred on the date and hour and from the causes stated above. (If well (did) did not see the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Myron L. Lenka</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | DATE SIGNED
<i>2/12/85</i> | | |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MYRON L. LENKA MD</i> | | | 22d. ADDRESS
<i>3309 Shorefield Wheaton MD</i> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>FEB 22 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>QUANTICO NAT. PARK</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>TRIANGLE, VIRGINIA</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>W.H. BACON FUNERAL HOME INC. 3447 14TH ST, N.W.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 21 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>W. Davidson-Randall</i> | | | |

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MARS 1 1963

079035

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Mary C. Osborne | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 14, 1985 | | 2b. HOUR
5AM M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 6, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
S.S. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
12517 Waldo Lane | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Sales | | 12b. KIND OF BUSINESS OR INDUSTRY
Sears Roebuck Co. |
| 13a. STATE
Md. | | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
S.S. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Saverio Buonviri | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Concetta DelCasale | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
None | | 16b. SOCIAL SECURITY NO.
579 07 9206 | | 17. INFORMANT
Same as 13c
Edith B. Sapienza (Sister) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lung Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 16</u> 19 <u>84</u> to <u>March 13</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>Feb 13</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Harvey Katzen</u> MD | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Harvey Katzen, M.D. | | 22e. ADDRESS
Suite 460
6525 Belcrest Road Hyatts. Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
3/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Cemetery Wash. D.C. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 15 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Rendall</u> | | | | | |

MEDICAL CERTIFICATION

99

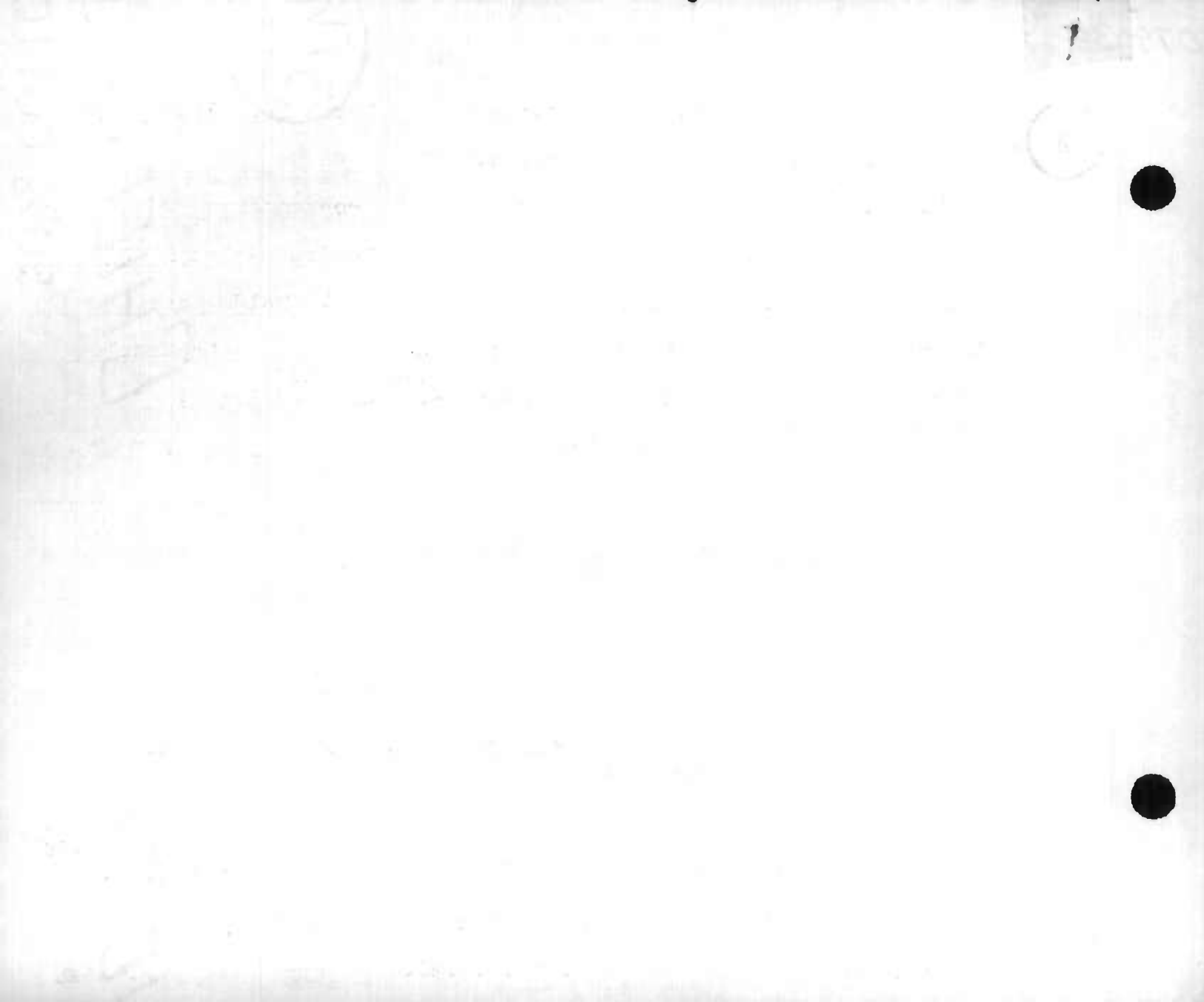
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP



Milton Oshero

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

092128

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS INCURRED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 6 AND 7 TO THE MEDICAL EXAMINER. GIVE PAGES 8 AND 9 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M 3. RETAIN PAGE 5. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS OF DEATH, WITH THE DIVISION OF VITAL RECORDS, 501 WEST BALTIMORE, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

| | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|---|--|----------|-------------------|--|----------------|--------------------------------------|------------------|--|--------------------------|-----|-------|-----------------------------------|----------|---|------|----------------|----------|----------------------------|-----|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | ESTIMATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | MIN | | SEC | | |
| Milton | | | | | | Osheroff | | March 24, 1985 | | 12 | | 00 | | 00 | | 1985 | | 12 | | 00 | | 00 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | | MIN | |
| M | | W | | May 28, 1950 | | | 50 YRS. | | MONTHS | | DAYS | | HOURS | | MIN. | | March 24 | | 19 | | 50 | | A | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | |
| NEW YORK | | | | USA. | | | | | | | | Montgomery MD | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| St. L. Spg. | | | | 13155 Fenwick Lane Apt 1102 | | | | | | | | ATTORNEY | | | | LAW | | | | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS | | | | | | | | |
| MD | | | | Mont | | | | St. L. Spg. | | | | | | | | 13155 Fenwick Lane Apt 1102 | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | | | | | | |
| MORRIS | | | | OSHEROFF | | | | RACHEL WEISSMAN | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | | | | |
| YES | | | | WWII | | | | UNKNOWN | | | | MINNA ROSDOL (SISTER) | | | | 9502 WIRE AVE. SILVER SPRING, MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>Immune Deficiency Dis.</u> | | | | | | | | | | | | | | | | | | 10 yrs | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | | | 20. AUTOPSY? | | | | | | |
| None | | | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | |
| | | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION | | | | | | | | | | | | | | | | |
| | | | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | | | | | TITLE (SPECIFY) | | | | | | | | | | DATE SIGNED | | | | |
| John S. Rogers | | | | | | | | | | M.D. Dep. | | | | | | | | | | March 24, 1985 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | |
| JOHN S. ROGERS | | | | | | | | | | 1919 Seminary Rd. Silver Spring, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION | | | | | | | | | | | | |
| BURIAL | | | | MARCH 26, 1985 | | | | KING DAVID CEMETERY | | | | FAIR CHURCH, VIRGINIA | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| NAME ADDRESS | | | | | | | | | | MAR 29 1985 | | | | | | | | | | | | Lia Davidson-Randall | | |
| CHAMBERS FUNERAL HOME | | | | | | | | | | SILVER SPRING, MD. | | | | | | | | | | | | | | |

BP_____

DHMH - 17

(VR A15 ME (5))

082163

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
William Edgar Owen | | | 2a DATE OF DEATH
MONTH DAY YEAR
March 4, 1985 | | 2b HOUR
7:00a.m. |
| 3 SEX
Male | 4 RACE
Caucasian | 5 DATE OF BIRTH
MONTH DAY YEAR
Nov. 29, 1903 | | 6 AGE (IN YEARS LAST BIRTHDAY)
81 YRS | |
| 7a BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Kentucky | 7b CITIZEN OF WHAT COUNTRY?
United States | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3443 South Leisure World Blvd | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | 12b KIND OF BUSINESS OR INDUSTRY
Automobile | |
| 13a STATE
Maryland | | | 13b COUNTY
Montgomery | 13c CITY OR TOWN
Silver Spring | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Edgar Owen | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Wilmuth | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
276-01-4469 | | 17 INFORMANT
ADDRESS
Lucille M. Owen, same as #13 | |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Chronic obstructive lung disease

DUE TO, OR AS A CONSEQUENCE OF

(c) Congestive Heart Failure

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|--|---|--|--|
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 6/17, 19 83, to PRESENT, 19 85, that (we) lost
saw the deceased above, 3/01, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b SIGNATURE
Alberto Rotsztain, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c DATE SIGNED
Mar. 4, 1985 |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS
3701 Rossmoor Blvd.
Silver Spring, MD 20906 | |

| | | | |
|--|--------------------------|--|---|
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b DATE
Mar. 8, 1985 | 23c NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring, Maryland | 23d LOCATION
CITY OR TOWN COUNTY STATE |
| 24 FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes,
P.A. Rockville, Maryland | | 25a DATE REC'D. BY REGISTRAR
MAR 8 1985 | 25b REGISTRAR'S SIGNATURE
[Signature] |

F

1

215

Confidential
Security of Information
and Privacy Act

10/1/80
10/1/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

100072

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|-----------------------|---|---|--|--|--|---|---|--|--|-----------------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles E Owens | | | 2a. DATE OF DEATH
MONTH 3 DAY 30 YEAR 85 | | | 2b. HOUR
6 35 P M | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
BLK | | 5. DATE OF BIRTH
MONTH 6 DAY 11 YEAR 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS
HOURS 0 MIN. 0 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda Md. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
STRAILROAD | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |

| | | | | | | | | | | | |
|---|--|-------------------------------|--|---|--|--|--|--|--|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS / ZIP CODE
7807 SCOTLAND DR. 20854 | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGO. | | 13c. CITY OR TOWN
ROCKVILLE | | | | | | | |
| 14. FATHER'S NAME
FIRST DENNIS MIDDLE OWENS LAST OWENS | | | | 15. MOTHER'S MAIDEN NAME
FIRST MARTHA MIDDLE DORSEY LAST DORSEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | | | 17. INFORMANT
ADDRESS 8819 TALLEYHUB TRAIL
William OWENS-SON, POTOMAC, MD. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory insufficiency

DUE TO, OR AS A CONSEQUENCE OF

(b) **chronic obstructive pulmonary disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**Immediate****10yr-standing**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

Prostatic Cancer

| | | | | | | | |
|------------------------------------|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------------------|--|--|--|--|--|---|--|

| | | | | | |
|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
— | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION
STREET — CITY OR TOWN — COUNTY — STATE — | |

22a. I certify that (a) (this hospital) attended the deceased from **3/25**, 19 **85**, to **3/30**, 19 **85**, that (b) (we) lost
saw the deceased give up **3/30**, 19 **85**, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above (c) (we) (did/did not) view the body after death.

| | | | | | | | |
|--|--|---------------------|--|--|--|------------------------------------|--|
| 22b. SIGNATURE
Ira Paul Kresting | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-31-85 | |
|--|--|---------------------|--|--|--|------------------------------------|--|

| | | | |
|---|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IRA PAUL KRESTING | | 22e. ADDRESS
2101 Medical Park Silver Spring 20902 | |
|---|--|--|--|

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK)
BURIAL | | 23b. DATE
4-5-85 | | 23c. NAME OF CEMETERY OR CREMATORY
RESTHAVEN CEM. | | 23d. LOCATION
CITY OR TOWN FREDERICK, Fred. COUNTY M.D. STATE — | |
|---|--|----------------------------|--|---|--|---|--|

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME GEORGE A. SNOWDEN | | 24b. ADDRESS
246 N. WASH. ST. ROCKVILLE, MD. | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | |
|---|--|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

7-2-1

081152

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08980

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|------------------|---|---|---|---|--|--|---|------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
David L. Papermaster | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> 3-13 19 85 | | | 2b. HOUR
M | | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 12, 1939 | 6. AGE (IN YEARS LAST BIRTHDAY)
45 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
3-14 19 85 | | | 2d. HOUR
8:23 a. M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | |
| 10. CITY OR TOWN OF DEATH
Potomac | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11406 Beechgrove Lane | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Financial Analyst Econ. Dev. Adm. | | | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Potomac | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11406 Beechgrove Lane 20854 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry J. Papermaster | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Klig | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
----- | | 17. INFORMANT
11406 Beechgrove Lane
Stephen J. Papermaster; Potomac, Md. 20854 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Dennis F. Smyth</i> | | | TITLE (SPECIFY)
Assistant | | | | MEDICAL EXAMINER | | DATE SIGNED
3-14-85 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Dennis F. Smyth, M.D. | | | ADDRESS
111 Penn St., Balto., Md. 21201 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
3-18-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Milwaukee, Wisconsin | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Chapels; 1170 Rockville Pike | | | ADDRESS
Rockville, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 19 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

SEP 120

SEP 14 1964

SEP 14 1964

SEP 14 1964

SEP 14 1964

SEP 14 1964

SEP 14 1964



BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

008129

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
LAST MIDDLE FIRST
ADA PAPST | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 31 85 | | | 2b. HOUR
903 P.M. | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 8 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Sales person | | | 12b. KIND OF BUSINESS OR INDUSTRY
Kann's Store | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10700 Huntwood Drive 20901 | |

| | | | | | |
|---|--|--|---|---|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin Dwyer | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha D. Van Horn | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
N/A | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT
ADDRESS
William Grass-Executor- 5811 Potomac Ave., NW
Washington, DC | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST.</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ASPIRATION PNEUMONITIS</u> | | 3 Hour | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>BOWEL OBSTRUCTION</u> | | 2 DAYS | |

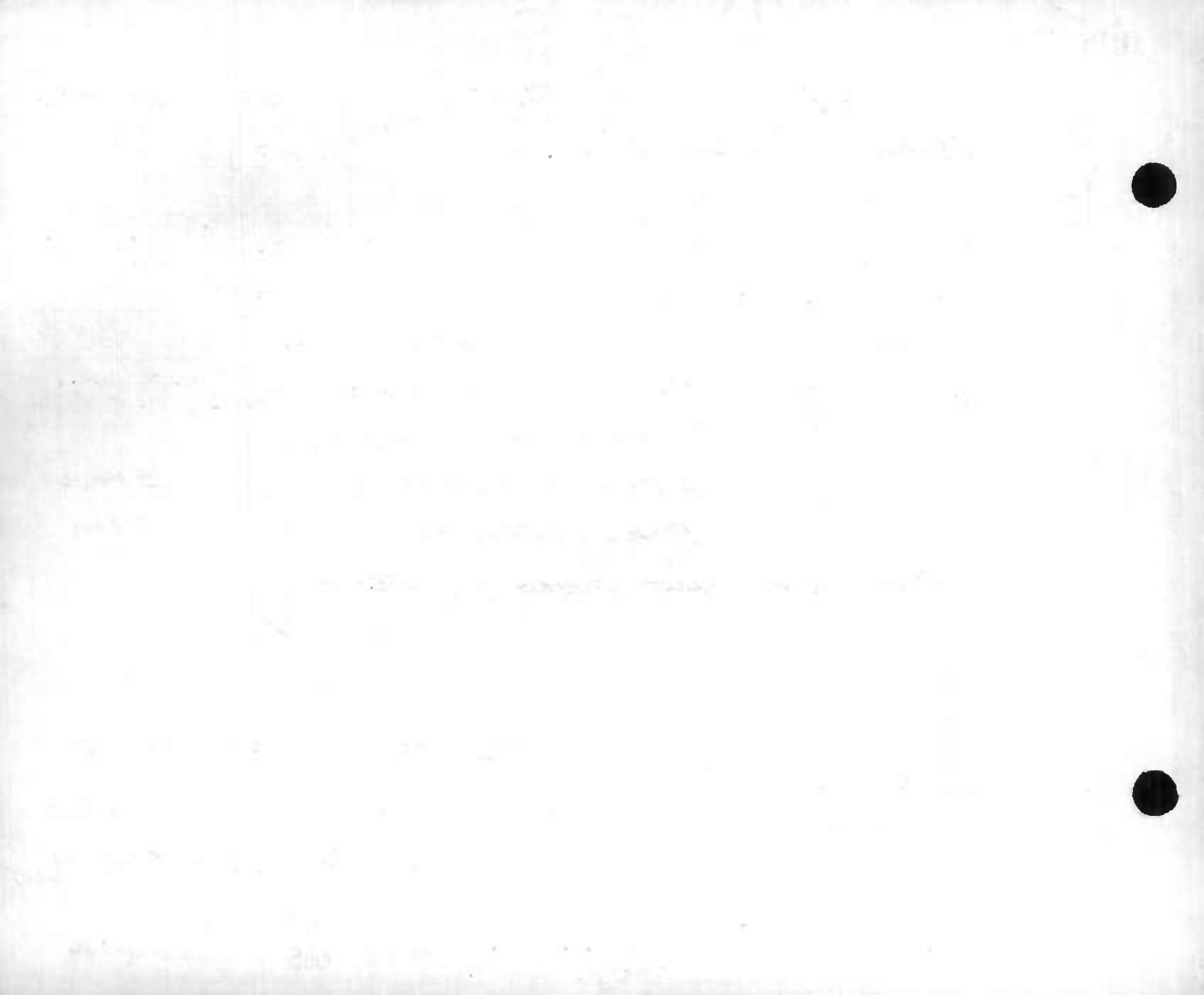
| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ATHERO SCLEROTIC HEART DISEASE : A20TEMIA.</u> | | | |
|--|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

| | |
|---|--|
| 22a. I certify that (1) this hospital attended the deceased from <u>3/31</u> 19 <u>85</u> to <u>3/31</u> 19 <u>85</u> , that (2) we last saw the deceased alive on <u>3/31</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (3) I did (did not) view the body after death. | |
|---|--|

| | | | | | | | |
|---|--|--------------|--|--|--|-----------------------------|--|
| 22b. SIGNATURE
<u>Alan Jay Diamond</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/31/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN JAY DIAMOND | | | | 22e. ADDRESS
1106 SPRING STREET, SILVER SPRING, MD 20905 | | | |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Apr. 3, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, DC | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | 11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 2 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John H. Parisi | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 15, 1985 | | | 2b. HOUR
5:33 pm | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 11, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County Maryland MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NO IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Program Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Research | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8 Columbia Ct.
Rockville, Maryland 20850 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Parisi | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gaanna Mazzara | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
Yes WWII | | | 16b. SOCIAL SECURITY NO.
098-05-7498 | | 17. INFORMANT
Jo Ann Parisi (Wife) 8 Columbia Ct.
Rockville, Maryland 20850 | | | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hypotension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Autoimmune Hemolytic Anemia</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
<u>Chronic Lymphocytic Leukemia</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 min.</u>
<u>2 days</u>
<u>3 days</u> | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11 November</u> , 19 <u>84</u> , to <u>15 March</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>15 March</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) see the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Jules R. Lodish</u> | | | | | DEGREE
<u>M.D.</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
March 15, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>JULES R. LODISH</u> | | | | | 22e. ADDRESS
2901 Olney-Sandy Spring Rd.
Olney, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
1985
March 18 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery Silver Spring, Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
300 West Montgomery Avenue Rockville, Md. 20850 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1985 | | | | | 25b. REGISTRAR'S SIGNATURE
<u>J. Davidson-Rendall</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) PHILLIP EUGENE PEARSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 7, 1985 | | 2b. HOUR
5:20 ^a _M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
DEC. 14, 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY)
36 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS
39 MONTHS 27 DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ARKANSAS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY, MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CLINICAL CENTER (NIH) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ANTIQUE DEALER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MISSISSIPPI 13b. COUNTY TERRY 13c. CITY OR TOWN TERRY | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LOUIS E. PEARSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ETHELYNE E. LOUCKS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
442-48-2543 | | 17. INFORMANT ADDRESS
MRS. ETHELYNE PEARSON (MOTHER) EDMOND, OK | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) KAPOSI SARCOMA, PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) ACQUIRED IMMUNE DEFICIENCY SYNDROME
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 4, 1984 to MARCH 7, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 7, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (xxx) view the body after death. | | | | | |
| 22b. SIGNATURE
Rudolph E. Welles | | DEGREE
M.D. | | 22c. DATE SIGNED
3/7/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rudolph E. Welles | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH
CLINICAL CENTER, BETHESDA, MD 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
3-9-85 | | 23c. NAME OF CEMETERY OR CREMATORY
MEMORIAL PARK CEMETERY OKLAHOMA CITY OK OK | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
OKLAHOMA CITY OK OK | | 24. FUNERAL DIRECTOR
BILL MERRITT 6201 N.W. 39 EXP BETHANY, OK | | | |
| 25a. DATE REC'D. BY REGISTRAR
APR 1 - 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

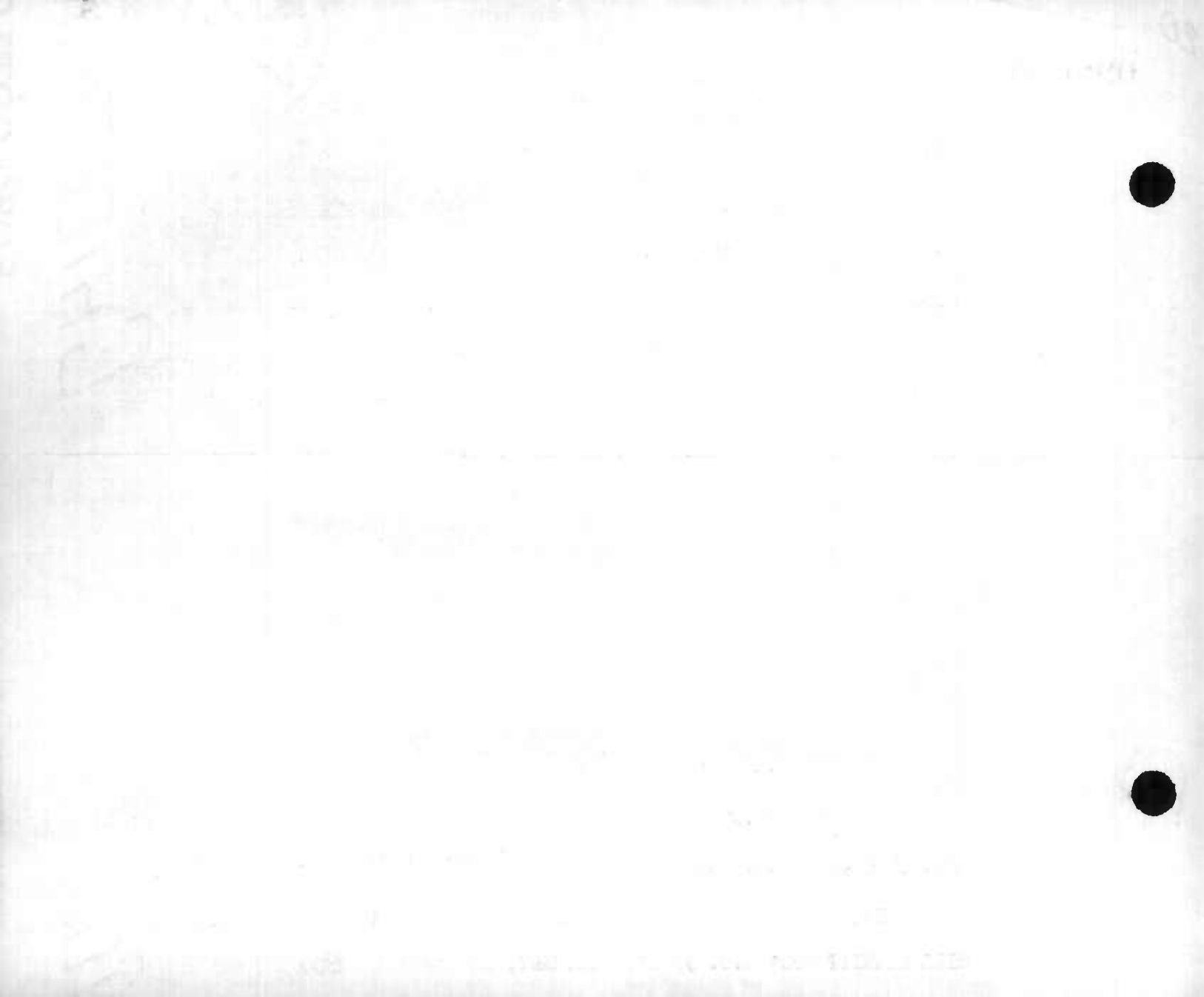
BP

DHWR 16 30M 4/85
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ROBERT SAMUEL PEEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 15, 1985 | | 2b. HOUR
11¹² P.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
3 23 99 | | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
North Carolina | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Insurance | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | 13b. COUNTY
Pr. Geo. | 13c. CITY OR TOWN
Univ. Park | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/>
6802 40th Avenue / 20782 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Claudius Peel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jennie Anderson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
577-09-4874 | | 17. INFORMANT
Ruth M. Peel, see 13e. (wife) | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Renal Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Advanced Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Cardiovascular Renal Disease | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
|---|--|---|

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

| | | | |
|--|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 79 to March 15, 19 85 , that (I) <input checked="" type="checkbox"/> lost
saw the deceased alive on March 15, 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. | | | |
| 22b. SIGNATURE
Richard L. Whelton M.D. | | DEGREE
M.D. | 22c. DATE SIGNED
3-16-85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD L. WHELTON | | 22e. ADDRESS
7100 BALT. AVE COLLEGE PARK MD 20740 | |

| | | | |
|---|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/19/85 | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md 20740 |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home, Inc. | | 25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 20 1985 Richard Anderson | |
| 11800 New Hampshire Avenue, S.S., MD 20904 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1-
FOR
STATE
REGISTRAR

| | | | | | | | |
|---|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| JULIUS PERLSTEIN Pearlstein | | | | MARCH 27 1985 | | 6:05 P _M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | |
| MALE | CAUCASIAN | MONTH DAY YEAR
JANUARY 24 1908 | | 77 | | IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| NEW YORK | | UNITED STATES | | | | MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| BETHESDA | NAVAL HOSPITAL | | | RETIRED | | WAITER | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. CITY OR TOWN | | 13b. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE
VIRGINIA | | 13b. COUNTY
STAFFORD | | 9 ROLLING ROAD 22554 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| MORRIS PERLSTEIN Pearlstein | | REBECCA KELLNER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | 22554 | |
| NO | | 055-03-1962 | | JANET GITLIN, 9 ROLLING ROAD, STAFFORD VA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 20</u> 19 <u>85</u> , to <u>MARCH 27</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>MARCH 27</u> 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE
 | | | | 22c. DATE SIGNED
28 MAR 85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
H. P. LIEBERT, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND
NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 3/29/85 | | Mt. Ararat Cemetery | | Farmingdale, New York | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 Rockville Pike; Rockville, Md. 20852 | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
APR 1 1985 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18, no injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

2892

1-2880

20% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician.)

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|---|--------------------------|--|---|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 8 5 0 8 9 8 6 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Gilbert V Perry | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3-28-85 | | | | | 2b. HOUR 7:30 M | |
| 3. SEX Male | | 4. RACE CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR 9 6 01 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (COUNTRY) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD | | | | | |
| 10. CITY OR TOWN OF DEATH Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINCIPAL | | 12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL | | | |
| 13a. STATE PENNSYLVANIA | | 13b. COUNTY LUZERNE | | 13c. CITY OR TOWN WYOMING | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 544 WYOMING AVENUE 18644 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PERRY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECELIA CURRY | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO | | | | | 16b. SOCIAL SECURITY NO. 179-28-5441 | | 17. INFORMANT ADDRESS KATHRYN F. PERRY SAME AS 13 WIFE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure | | | | | | | | | | minutes | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic obstructive pulmonary disease | | | | | | | | | | 3 mo | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the lung | | | | | | | | | | 3 mo | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14 19 85 to 3/28 19 85 , that (I) (we) last saw the deceased alive on 3/27 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Richard O. Delaney | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 3/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD O. DELANEY MD | | | | | 22e. ADDRESS 4323 HANARD ST. SIL. SPR. MD 20916 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 3/30/85 | | 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | | 23d. LOCATION CITY OR TOWN COUNTY STATE CARVERTON LUZERNE PA. | | | |
| 24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS | | | | | 25a. DATE REC'D. BY REGISTRAR APR 1 1985 | | | | | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | 25b. REGISTRAR'S SIGNATURE John Davidson | | | | | | |

003126



WIFE 01 CA JUNE 13

5093102

1- STATE REGISTRAR Minnie T. Perry MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|---------------------|---|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Minnie T. Perry | | | 2a. DATE KNOWN OF DEATH
ESTIMATED MAR. 26 1985 | | | 2b. HOUR
9:45 M | | |
| 3. SEX
F | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR JAN 8 1928 | 6. AGE (IN YEARS)
LAST BIRTHDAY 57 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN | 2c. DATE PRONOUNCED DEAD
MAR. 26 1985 | | 2d. HOUR
M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | |
| 11. CITY OR TOWN OF DEATH
Sr. Spring | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Belty Creek Hosp | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Md. | | 13b. COUNTY
Montg. | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
13306 Patridge Dr. 20904 |
| 14. FATHER'S NAME
FIRST Lemuel MIDDLE Taylor LAST Taylor | | 15. MOTHER'S MAIDEN NAME
FIRST Cora MIDDLE Overton LAST Overton | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | | |
| 16b. SOCIAL SECURITY NO.
246-56-7824 | | 17. INFORMANT
ADDRESS Doris Poole (Daughter) Same AS #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) Carcinoma of pancreas
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).
None | | | | | | | | |
| 19a. DATE OF OPERATION
None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE
[Signature] | | TITLE (SPECIFY)
MD. | | MEDICAL EXAMINER
[Signature] | | | DATE SIGNED
March 26 1985 | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
3-27-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Walson Funeral Home | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elizabeth City N.C. | |
| FUNERAL DIRECTOR
NAME
George R. Snouden | | ADDRESS
246 N. WASH. ST. Rockville, Md. 20851 | | 25a. DATE REC'D. BY REGISTRAR
MAR 29 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP

 DHMH - 17
 (VR A15 ME (5))
 20M 4/82

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925114 11011X

QND B



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 8 8

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | |
|--|--|--|--|---|----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Enio O. Persion | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 7, 1985 | | 2b. HOUR
H 47 A M | |
| 2. SEX
Male | | 4. RACE
White | | 3. DATE OF BIRTH
MONTH DAY YEAR
June 16 1910 | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tech. Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY
W.G. Cornell Co. | | | | |
| 13a. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
A. P. Persion | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Irene Deprofio | | 13d. STREET ADDRESS / ZIP CODE
9902 Sutherland Road | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, HOW AND WHERE) (IF YES, GIVE DATE OR DATES)
N/A | | 16b. SOCIAL SECURITY NO.
320-03-7595 | | 17. INFORMANT
ADDRESS
Loretta H. Persion-wife-Same as 13c | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Ischemia</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | |
| MEDICAL CERTIFICATION | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21; PART I OF PART II) | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14 19 85 to 1/16/85 19 85, that (I) (we) last saw the deceased alive on 1/14/85 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Hector Collison, MD</u> | | 22c. DEGREE
DEGREE | | 22d. DATE SIGNED
3/7/85 | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Hector Collison, MD | | 22f. ADDRESS
1111 Spring St., Silver Spring, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar. 11, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln | | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi Funeral Home | | 24b. ADDRESS
11800 N.H. Ave.,
Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1985 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Ross</u> | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

CLEARED BY DR. ROGERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as resulting from self-inflicted injury, or other traumatic event, the medical examiner must be notified at once.

2017.10.10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

094024

| | | | | | | | |
|--|--|--|---|--|----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Ruby H. Peters</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 26 85</i> | | 2b. HOUR
<i>2249 PM</i> | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>Caucasian</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>July 13, 1901</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS
<i>83</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Pennsylvania</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County, MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Rockville</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Shady Grove Adventist Hosp</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Accounting Admin.</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY
<i>U.S. Gov't.</i> | | 13a. STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Bethesda</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William L. Henry</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Lyda Cribbs</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
<i>4522 Gladwyne Drive 20814</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>577 26 2074</i> | | 17. INFORMANT
ADDRESS
<i>Roland L. Peters husband same as 13e</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ischemic Heart Disease</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 HR.</i>
<i>5 YR.</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>Alzheimer's Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 26, 19 85</i> , to <i>March 26, 19 85</i> , that (I) (we) lost
saw the deceased alive on <i>March 26, 19 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Frank J. Mayo</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3-26-85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Frank J. Mayo, MD</i> | | 22e. ADDRESS
<i>16220 Frederick Rd.
Gothensburg, Md 20877</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Cremation</i> | | 23b. DATE
<i>March 27, 1985</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Metropolitan Crematory</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Alexandria Virginia</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Robert A. Pumphrey</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 1 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Julia T. ...</i> | |
| P.A., Bethesda, Maryland 20814 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I", the medical examiner must be notified of the death.

BP

034084

23 12 8

23-5

10-12

1. The first part of the report is a general description of the area. It is a small, flat, open area with a few scattered trees and shrubs. The ground is mostly bare and sandy.

2. The second part of the report is a description of the vegetation. There are a few small trees and shrubs, but most of the area is covered with low-lying plants and grasses.

3. The third part of the report is a description of the soil. It is a sandy, loamy soil with a high water table. The soil is generally dry and hard.

4. The fourth part of the report is a description of the water resources. There are a few small streams and ponds, but most of the water is underground. The water is generally of good quality.

5. The fifth part of the report is a description of the climate. It is a hot, dry climate with a high average temperature and low average precipitation.

6. The sixth part of the report is a description of the population. There are a few small villages and towns, but most of the population is concentrated in the larger cities.

7. The seventh part of the report is a description of the economy. It is a developing economy with a high average income and a low average unemployment rate.

8. The eighth part of the report is a description of the culture. It is a culture with a high average literacy rate and a low average life expectancy.

9. The ninth part of the report is a description of the future. It is a future with a high average growth rate and a low average inflation rate.

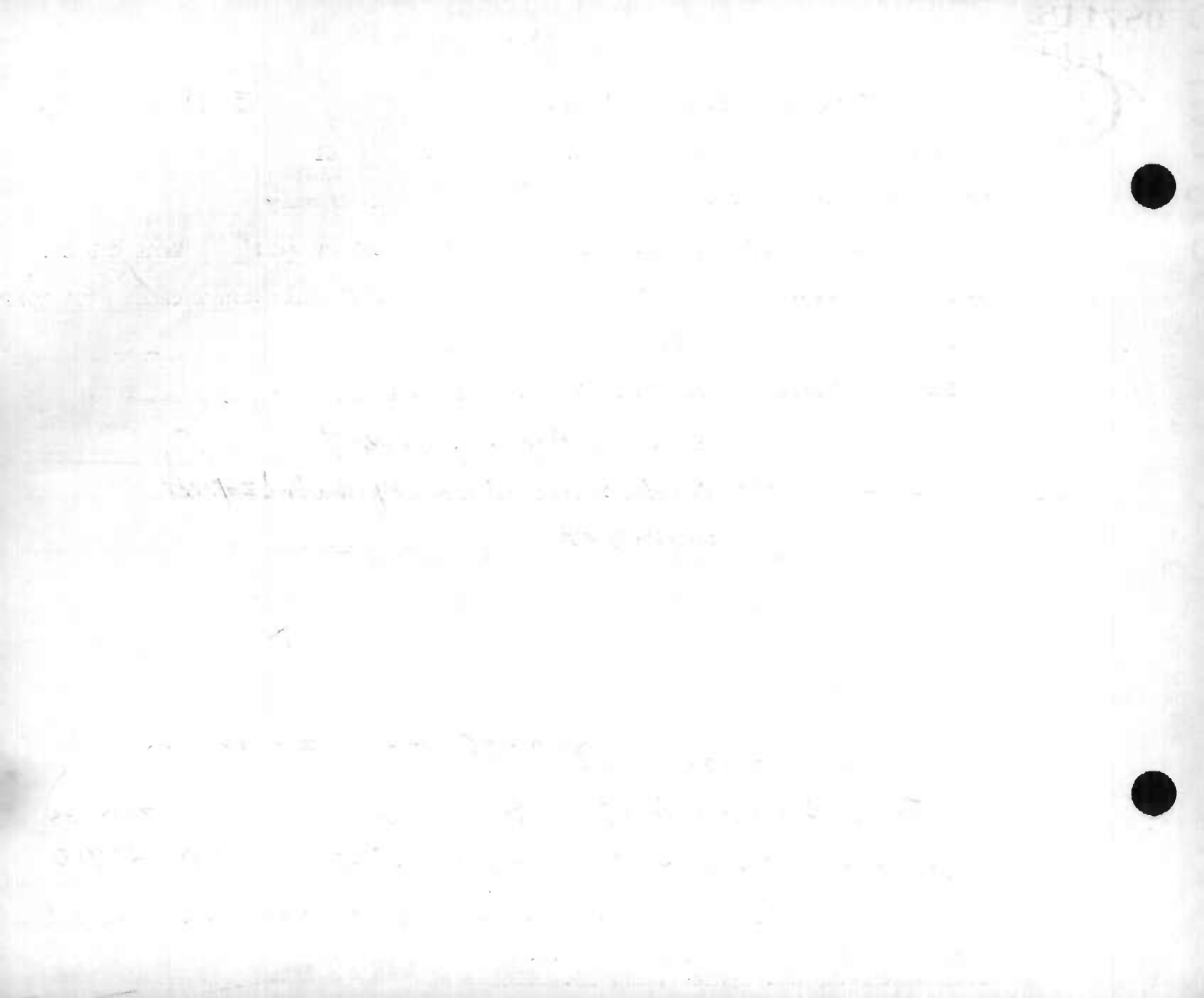
087118

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 9 0

| | | | |
|--|--|--|--|
| FOR
1- STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Joseph Benjamin Petrillo | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 18 85
2b. HOUR
11:41 AM | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
07 30 1923 | |
| 6. BIRTHPLACE
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. AGE (IN YEARS LAST BIRTHDAY)
61
YRS. | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | 10. CITY OR TOWN OF DEATH
Takoma Park | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Cab Driver | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Taxi Cab Co. | | 13. STREET ADDRESS / ZIP CODE
9131 Edmonston Terrace #204 20770 | |
| 14. FATHER'S NAME
Joseph Petrillo | | 15. MOTHER'S MAIDEN NAME
Annie Kidd | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
W.W.II 578-20-3724 | |
| 17. INFORMANT
Margaret E. Petrillo (Wife) | | 18. ADDRESS
Same as 13e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cardiogenic shock, Myocardial Infarct</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>EMPHASEMA</u> | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18 | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21a. INJURY OCCURRED
WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-9-85</u> , 19 <u>85</u> , to <u>3-18-85</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3-17-</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Tony P. Kannarkat | | 22c. DATE SIGNED
3/18/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
TONY P. KANNARKAT | | 22e. ADDRESS
8201 16th St, S.S MD 20910 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/21/85 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
Brentwood P.G. COUNTY Maryland | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
3749 Baltimore Ave. Hyattsville, Md. 20781 | | 25a. DATE REC'D. BY REGISTRAR
MAR 22 1985 | |
| 25b. REGISTRAR'S SIGNATURE
John E. ... | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



081040

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | |
|--|-------------------------|--|--|--|------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Charles Emory Phillips | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 12 1985 | | 2b. HOUR
1:30 A.M. | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 2 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF SUBMITTER GIVE STREET ADDRESS)
9010 Burning Tree Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Executive (Ret) | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Asa E. Phillips | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Estelle Randall | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
577-05-7109 | | 17. INFORMANT ADDRESS
Laura Emily Phillips, Same as item 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) coronary heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-30 19 79 , to present 19 _____, that (I) (we) last saw the deceased alive on 2-12 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
James H. Brodsky | | DEGREE
M.D. | | 22c. DATE SIGNED
March 12, 1985 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James H. Brodsky, M.D. | | 22e. ADDRESS
4701 Willard Avenue, #224
Chevy Chase, Maryland 20815 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/14/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Mem. Park Cem. | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1985 | | | | |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons Inc. | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | |
| 24. FUNERAL DIRECTOR
5130 Wisd. Ave., N.W. Wash. D.C. | | | | | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

074003

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 9 2

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(Print Name) <i>Edith</i> | | | MIDDLE <i>C.</i> | | | LAST <i>Pilgrim</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3/8/85</i> | | | 2b. HOUR <i>5:54</i>
MIN. <i>AM</i> | | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>Can</i> | | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>4 23 98</i> | | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>86</i> | | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>IOWA</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery Cty.</i> | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Silver Spg.</i> | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Holy Cross Hospital</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Retired</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>GOV'T PRINTING OFF.</i> | | | | | | |
| 13a. STATE
<i>MD</i> | | | 13b. COUNTY
<i>Montgomery</i> | | | 13c. CITY OR TOWN
<i>Sil Spg</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS & ZIP CODE
<i>12712 RIGDALE TERR. 20904</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>LAFAYETTE CALDWELL</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>MARY HERR</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | | 16b. SOCIAL SECURITY NO.
<i>59579-205125</i> | | | 17. INFORMANT
NAME ADDRESS
<i>CORALE P. SMITH SAME AS #13e (DAUGHTER)</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>PNEUMONIA</i> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>4 DAYS</i> | | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>AUG 84</i> to <i>8 MAR 85</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>7 MAR 85</i> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Walter E. Goode MD</i> | | | | | | | | | | | | DEGREE | | 22c. DATE SIGNED
<i>9 MAR 85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>WALTER E. GOODE MD</i> | | | | | | | | | | | | 22e. ADDRESS
<i>2309 SHOREFIELD RD WHEATON MD</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>3/11/85</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>PARKLAWN CEMETERY</i> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>ROCKVILLE, MONT. MD</i> | | | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Francis J. Collins</i>
<i>500 University Blvd., W., Silver Spring, MD</i> | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 13 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | |

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the medical examiner must be notified at once.



Vertical text on the left margin, possibly a list or index, including words like "CO", "NO", and "I".

TO SHARP

ON 4/10/10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 9 9 3

REG. NO.

0940252

| | | | | | | | | |
|---|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN JOSEPH PISANO | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 26 1985 | | 2b. HOUR
2:47 P.M. | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 14 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County, MD. | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BIOCHEMIST | | 12b. KIND OF BUSINESS OR INDUSTRY
N.I.H. | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
1082 LARKSPUR TERRACE 20850 | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
PAUL PISANO | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ANNA TAORMINA | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
171-22-6143 | | 17. INFORMANT
ADDRESS Rockville, Md.
JANE C. PISANO, 1082 LARKSPUR TERRACE, | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 26 , 19 85 , to MARCH 26 , 19 85 , that (I) (we) last saw the deceased alive on MARCH 26 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22a. SIGNATURE
 | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
27 MAR 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. L. GRIFFEN, III, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
Cremation | | 23b. DATE
March 30, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND | | | | 25. DATE OF DEATH BY REGISTRATION
APR 1 1985 | | | | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

001030



X

1/1/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
John Howard POMEROY | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/15/85 | | | 2b. HOUR
11 AM | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 / 5 / 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Florida | | 7b. CITIZEN OF WHAT COUNTRY?
Montgomery | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Research scientist- | | 12b. KIND OF BUSINESS OR INDUSTRY
Sciences | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
5201-Fordyce Place 20814 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Howard Daniel Pomeroy | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Eva Watrous | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
221-05-7497 | | 17. INFORMANT
ADDRESS
Marian S. Pomeroy (Wife) Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) congestive cardiomyopathy | | | | | | | | years | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) arterio sclerotic heart disease | | | | | | | | 24 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
irreversible congestive heart failure, diabetes mellitus | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 21 19 61 to March 15 19 85 , that (I) (we) lost saw the deceased alive on March 15 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | | | 23b. DATE
Mar. 16, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Lee's Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
NAME
J. William Lee's Sons Co. | | | | | 25a. DATE REC'D. BY REGISTRAR
20002 | | 25b. REGISTRAR'S SIGNATURE
J. William Lee's Sons Co. | | | |
| 26. DATE
MAR 21 1985 | | | | | | | | | | |

MEDICAL CERTIFICATION

1

331000

2021-07-27 14:00:00 (UTC) 0

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

093046

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MAX | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 23, 1985 | | | 2b. HOUR
3:45 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
4 4 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HEBREW HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Automotive Equip. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abraham Poms | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Libby Goldberg | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-64-4115 | | 17. INFORMANT ADDRESS
Alvin Poms; 9 Leyton Court; Rockville, Md. 20850 | | | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 MIN
5 YEARS |
|--|--|---|

| | |
|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CARCINOMA LARYNX, LARYNGECTOMY 1974 | |
|---|--|

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (a) (this hospital) attended the deceased from 5/23/83 to MARCH 23 1985 , that (b) (we) saw the deceased alive on MARCH 23 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) | | | | | | | |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN LIPSON | | 22b. ADDRESS
6121 MONTROSE ROAD, ROCKVILLE | | 22c. DATE SIGNED
3/24/85 | | 22d. SIGNATURE
Steven Lipson MD | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/25/85 | | 23c. NAME OF CEMETERY OR CREMATORY
King David Mem. Gdn. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Falls Church; Fairfax; Va. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DANZANSKY-GOLDBERG MEMORIAL CHAPELS
1170 Rockville Pike; Rockville, Md. 20852 | | | | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 27 1985 <i>J. L. Davidson</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Betty V. Poole | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 14, 1985 | | 2b. HOUR
1:10 P. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
11 29 24 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
American | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | 12b. KIND OF BUSINESS OR INDUSTRY
Public School | |
| 13a. STATE
Maryland | | 13b. COUNTY
Frederick | 13c. CITY OR TOWN
Frederick | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
8053 Ball Road 21701 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wilfred Kline | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mamie Redmond | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-14-8572 | 17. INFORMANT
ADDRESS
Sandra Mullinix 9915 Watkins Rd. Gaithersburg, Md. | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sepsis
DUE TO, OR AS A CONSEQUENCE OF,
(b) metastatic breast carcinoma
DUE TO, OR AS A CONSEQUENCE OF,
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 days
4 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) this hospital attended the deceased from November 1980 to March 14 1985 , that (1) (we) last saw the deceased alive on March 13 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death. | | | | | |
| 22b. SIGNATURE
Cheryl E. Winchell M.D. | | | DEGREE
M.D. | 22c. DATE SIGNED
3/15/1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Cheryl E. Winchell, M.D. | | | 22e. ADDRESS
19241 Montg. Village Ave., Gaith., Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Bural | 23b. DATE
3/18/1985 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Olivet Ceme. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Frederick, Md. | |
| 24. FUNERAL DIRECTOR
NAME
Olin L. Molesworth, P.A., Funeral | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1985 | | |
| ADDRESS
Danville, Maryland | | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked as "Not while at work" or "Other traumatic event," the medical examiner must be notified.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

1:10 P. 1985 March 14, 1985 Betty V. Poola
Marlene White
Maryland American
Rockville Shady Grove Adventist Hosp. Secretary
Maryland Frederick Frederick
Wilfred Kline Jamie
210-14-8572 Sandra Wilkins
9015 Watkins Rd. Catonsville, Md.
Bedford

3/18/1985
Orryl E. Mitchell, M.D. 19241 Monte Village Ave., Catonsville, Md.
3/18/1985
Bural 3/18/1985 Mt. Olive Comm. Frederick, Md.

Olga I. Wolensworth, T.A., Funeral Director
3/18/1985

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MARY MIDDLE R. LAST POWER
MARY R. POWER | | 2a. DATE OF DEATH MONTH DAY YEAR
3-28-85 | | 2b. HOUR
4:15 M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
08 27 03 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Mont. | | MD. | | | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
HOLY CROSS HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSE WIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
9202 WENDELL ST. 20901 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
WILLIAM GRIMES | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ALICE KEARON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-46-8491 | | 17. INFORMANT (DAUGHTER) ADDRESS
JUNE MONTAGUE, 9026 PIXIE CT., FAIRFAX, VA. 22031 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Pulmonary Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Organ Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiomyopathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs.
2 hrs.
Chronic | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION
2/14/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Resectomy for Duodenal Cancer | | 19c. AUTOPT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY (IF HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14/85 , 19 85 , to 3/28 , 19 85 , that (I) (we) lost saw the deceased alive on 3/28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Steven Christian M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
3/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN CHRISTIAN M.D. | | 22e. ADDRESS
344 University Blvd. Silver Spring MD 20901 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | 23b. DATE
3/29/85 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | |
| 23d. LOCATION
SUITLAND | | 23e. COUNTY
PG. MD. | | | |
| 24. FUNERAL DIRECTOR RICHARD RAPP, INC. | | | | | |
| NAME
1804 T ST., N.W., WASH., D.C. 20009 | | 25a. DATE REC'D. BY REGISTRAR APR 1 1985 | | | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes," any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
XENIA N. PRIANISHNIKOFF | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 4, 1985 | | | 2b. HOUR
12:10 PM | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
APRIL 23, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
SILVER SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CARRIAGE HILL NURSING HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LINGUIST | |
| 12b. KIND OF BUSINESS OR INDUSTRY
LINGUIST | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
SILVER SPRING | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
8708 1st AVE. / 20910 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NICHOLAS - BONAFEDE | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LARISSA - KRAMAREFF | | | |

| | | | | | |
|--|--|---|--|---|--|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
NONE 061-26-0441 | | 17. INFORMANT
ADDRESS
BORIS PRIANISHNIKOFF (HUSBAND) SAME AS #13. | |
|--|--|---|--|---|--|

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastatic Colon Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
24 hours |
|--|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18 OR PART 1 OR PART 2) | | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (i) (this hospital) attended the deceased from 3/2/85 to 3/4/85, and that (ii) (we) last saw the deceased alive on 3/2/85, and that (iii) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | |
| 22a. SIGNATURE
PENNY BISK | | | | 22b. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
MARCH 4, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. PENNY BISK, MD. | | | | 22e. ADDRESS
10313 GEORGIA AVE. SILVER SPRING, MD. | | | |

| | | | | | | | |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
3-6-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | | 23d. LOCATION
(CITY OR TOWN) COUNTY STATE
WASHINGTON, D.C. | |
|--|--|-----------------------|--|---|--|--|--|

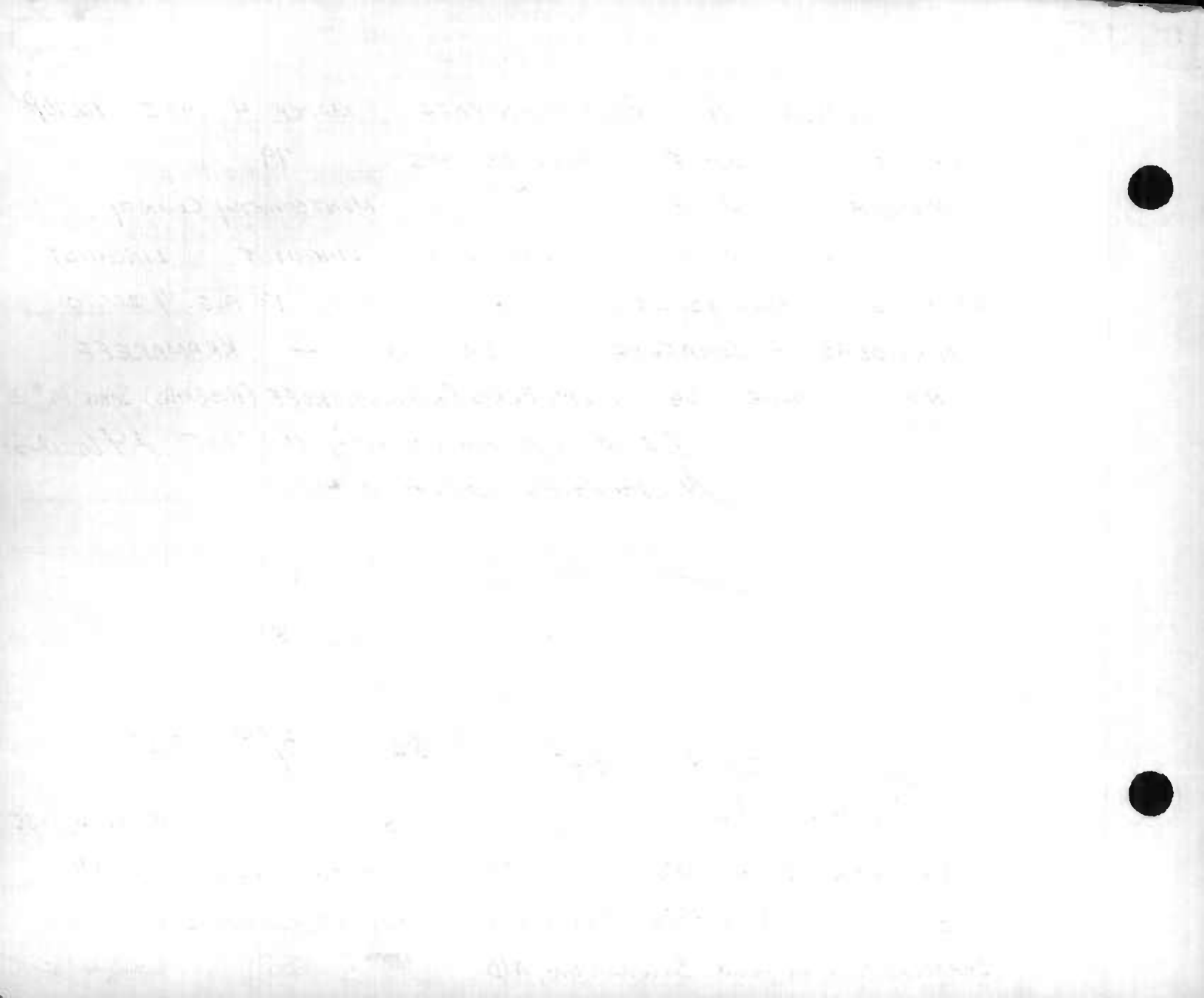
| | | | | | | | |
|---|--|-------------------------------|--|---|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
CHAMBERS FUNERAL HOME | | ADDRESS
SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR
MAR 7 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
|---|--|-------------------------------|--|---|--|--|--|

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (i), it allows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Henry Price | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
3-8 19 85 | | | 2b. HOUR
M
a. | | |
| 3. SEX
Male | 4. RACE
Cauc. | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 8, 1911 | 6. AGE (IN YEARS)
LAST BIRTHDAY
73 YRS. | IF UNDER 1 YR.
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3-8 19 85 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Topographer | | 12b. KIND OF BUSINESS OR INDUSTRY
Army Map Service | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Gaithersburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Archie Price | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gertie Pool | | | 16. SOCIAL SECURITY NO.
402-10-5258 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1942-1962 | | | 17. INFORMANT
ADDRESS
Mildred K. Price, same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Chronic Obstructive Pulmonary Disease</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | |
| ACTUAL SIGNATURE
EXAMINER'S NAME (TYPE OR PRINT)
Gregory R. Kauffman, M.D. | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | DATE SIGNED
3-9-85 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
March 12, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Humphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1985 | | | |

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Bessie B. Ramey | | | 2a. DATE OF DEATH
MONTH 3 - DAY 16 - YEAR 85 | | 2b. HOUR
11:15 PM |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH July DAY 4 YEAR 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS | IF UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Office worker | | 12b. KIND OF BUSINESS OR INDUSTRY
unknown |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Virginia | | 13b. COUNTY Fairfax | 13c. CITY OR TOWN Fairfax | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
10701 Main Street 99999 |
| 14. FATHER'S NAME
FIRST Frank MIDDLE LAST Ramey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE Johnson LAST | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
577-01-7103 | | 17. INFORMANT
ADDRESS Md.
Rev. Richard Reichard 9701 Veirs Dr. Rockville, | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b)
DUE TO, OR AS A CONSEQUENCE OF(c) APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**5 days**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **alzheimer's disease**

| | | | | | |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION
Sept 8 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) the hospital attended the deceased from Sept 8 , 19 85 , to March 16 , 19 85 , that (1) (we) lost
saw the deceased alive on March 15 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Harold F. M. Cann | | DEGREE
M.D. | | 22c. DATE SIGNED
3-17-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. M. CANN | | 22e. ADDRESS
3355-16th St. N.W. WASH D.C. 20010 | | | |

| | | | |
|---|------------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) burial | 23b. DATE
March 20, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Massanutten Cemetery | 23d. LOCATION
CITY OR TOWN Woodstock COUNTY Virginia STATE |
| 24. FUNERAL DIRECTOR
NAME Hysong Co. Inc. ADDRESS 1300 N St. N.W. Wash. D.C. | | 25a. DATE REC'D. BY REGISTRAR APR 02 1985 25b. REGISTRAR'S SIGNATURE John Davidson | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

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1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 0 1

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Huldah W. Randell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Mar. 8, 1985 | | | 2b. HOUR
9:25p M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
3 20 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 9b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY | | 13c. CITY OR TOWN
Sandy Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
17300 Quaker Lane 20860 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Christian Weishaar | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katharine Conrad | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Unkn. | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-14-0422 | | 17. INFORMANT ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular failure
DUE TO, OR AS A CONSEQUENCE OF (b) Massive Brain Stem Infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Stroke
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Stroke | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
3/5 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/5 , 19 85 , to 3/8 , 19 85 , that (I) (we) last saw the deceased alive on 3/8 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (our) body after death. | | | | | | | | | | |
| 23a. SIGNATURE
C. H. [Signature] | | | 23b. DEGREE | | | 23c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 23d. DATE SIGNED
3/8/85 | |
| 24a. PHYSICIAN'S NAME (TYPE OR PRINT)
C. H. [Signature] | | | 24b. ADDRESS
1814 30th St Olney, MD 20832 | | | | | | | |
| 25a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 25b. DATE
3/10/85 | | 25c. NAME OF CEMETERY OR CREMATORY | | | 25d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 26. FUNERAL DIRECTOR
NAME
Anatomy Board | | | | | 26a. DATE REC'D. BY REGISTRAR
MAR 15 1985 | | 26b. REGISTRAR'S SIGNATURE
[Signature] | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

020012

BOX COLLECTOR 1000

WAVE 1000



1000

1000 1000 1000

078023

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8509002

1- FOR
STATE
REGISTRAR JEANNETTE M. RANFT

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Jeannette</u> <u>M</u> <u>RANFT</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>MARCH</u> <u>16</u> <u>85</u> | | | 2b. HOUR <u>12</u> <u>A</u> <u>M</u> | | | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH MONTH DAY YEAR
<u>April</u> <u>24</u> , <u>1910</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>74</u> YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 8. BIRTHPLACE (COUNTRY)
<u>Maryland</u> | | 9. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> <u>County</u> <u>MD</u> | | | |
| 12. CITY OR TOWN OF DEATH
<u>Gaithersburg</u> | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Adelphi Health Care Center</u> | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | | 15. KIND OF BUSINESS OR INDUSTRY
<u>Advertising</u> | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
<u>Maryland</u> | | 16b. COUNTY
<u>Baltimore</u> | | 16c. CITY OR TOWN
<u>Catonsville</u> | | 16d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 16e. STREET ADDRESS / ZIP CODE
<u>1077 Southridge Road</u> <u>21228</u> | |
| 17. FATHER'S NAME FIRST MIDDLE LAST
<u>William</u> <u>B.</u> <u>Leopold</u> | | | | 18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<u>Mary</u> <u></u> <u>Hales</u> | | | | | |
| 19. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<u>No</u> | | 20. SOCIAL SECURITY NO.
<u>212-09-2741</u> | | 21. INFORMANT
<u>Evelyn Bock</u> | | 22. ADDRESS
<u>2211 W. Rogers Avenue</u>
<u>Baltimore, Md.</u> | | 23. ZIP CODE
<u>21209</u> | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>4 years</u> | |
|--|--|--|--|

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>COPD, cor pulmonale.</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>P.M.</u> <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) this hospital attended the deceased from <u>Sept 17</u> , 19 <u>84</u> , to <u>March 15</u> , 19 <u>85</u> , that (ii) we saw the deceased alive on <u>March 5</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) we (did) (did not) view the body after death. | | | | | | | |

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 22b. SIGNATURE
<u>James R. Moore Jr.</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3-16-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>James R. Moore Jr.</u> | | 22e. ADDRESS
<u>207 Brookes Ave Gaithersburg Md</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>3/19/85</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lorraine Park Cemetery</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Woodlawn</u> <u>MD</u> | |

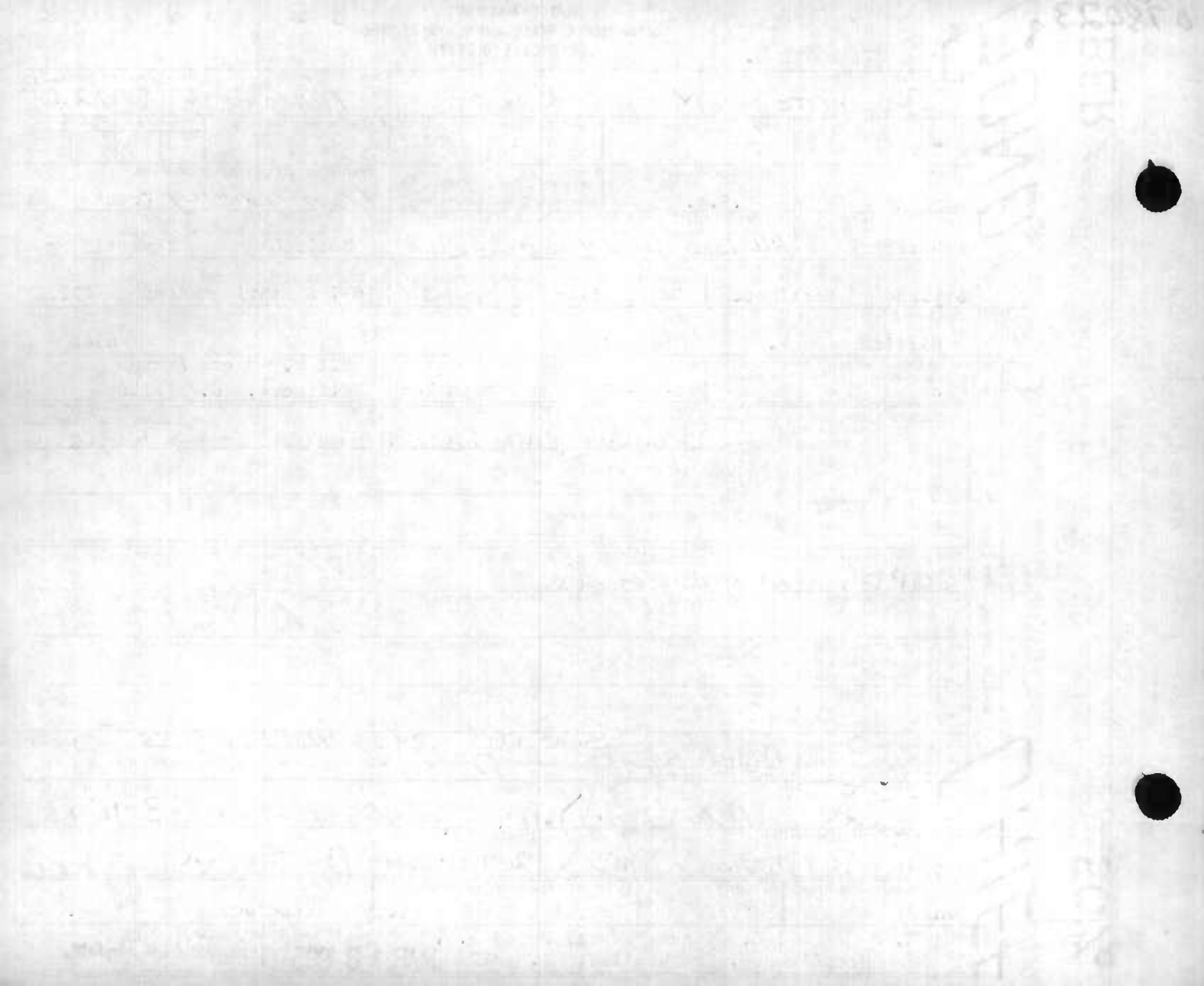
| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
NAME
<u>Leroy M. & Russell C. Witzke</u> | | ADDRESS
<u>Funeral Homes P.A.</u>
<u>1630 Edmondson Avenue, Catonsville, Md. 21228</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>MAR 18 1985</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | |
|---|--|--|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use as the burial permit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

BP



094015

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 0 3

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GORA H. RAYNIE | | | 2a DATE OF DEATH
MONTH DAY YEAR
3 27 85 | | 2b HOUR
2240 PM |
| 3 SEX
MALE | 4 RACE
CAUCASIAN | 5 DATE OF BIRTH
MONTH DAY YEAR
10 11 11 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
73 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
KENTUCKY | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County MD. | |
| 10 CITY OR TOWN OF DEATH
SILVER SPRING | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
PROCUREMENT OFFICER | | 12b KIND OF BUSINESS OR INDUSTRY
C.I. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
MARYLAND | | | 13b COUNTY
MONTGOMERY | | 13c CITY OR TOWN
WHEATON |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
GORA E. RAYNIE | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
GERTRUDE ROBERTSON | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b SOCIAL SECURITY NO
485-10-1401 | | 17 INFORMANT
ELEANOR V. RAYNIE |
| 18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4-wks
yes | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
Diabetes mellitus - renal failure - congestive heart failure | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21a INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/27 19 85 , to 3/27 19 85 , that (I) (we) last saw the deceased alive on 3/27 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE
OF PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD DELANEY MD | | DEGREE
MD | | 22c DATE SIGNED
3/28/85 | |
| 22d ADDRESS
4323 HARVARD ST SIL SPR 20906 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b DATE
3/30/85 | | 23c NAME OF CEMETERY OR CREMATORY
PARKLAWN CEMETERY | |
| 23d LOCATION
CITY OR TOWN COUNTY STATE
ROCKVILLE MONT. MD | | | | | |
| 24 FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | 25a DATE REC'D. BY REGISTRAR
APR 1 1985 | | 25b REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be retained by the funeral director. Page 4 may be retained by the funeral director. Page 5 may be retained by the funeral director. Page 6 may be retained by the funeral director. Page 7 may be retained by the funeral director. Page 8 may be retained by the funeral director. Page 9 may be retained by the funeral director. Page 10 may be retained by the funeral director. Page 11 may be retained by the funeral director. Page 12 may be retained by the funeral director. Page 13 may be retained by the funeral director. Page 14 may be retained by the funeral director. Page 15 may be retained by the funeral director. Page 16 may be retained by the funeral director. Page 17 may be retained by the funeral director. Page 18 may be retained by the funeral director. Page 19 may be retained by the funeral director. Page 20 may be retained by the funeral director. Page 21 may be retained by the funeral director. Page 22 may be retained by the funeral director. Page 23 may be retained by the funeral director. Page 24 may be retained by the funeral director. Page 25 may be retained by the funeral director. Page 26 may be retained by the funeral director. Page 27 may be retained by the funeral director. Page 28 may be retained by the funeral director. Page 29 may be retained by the funeral director. Page 30 may be retained by the funeral director. Page 31 may be retained by the funeral director. Page 32 may be retained by the funeral director. Page 33 may be retained by the funeral director. Page 34 may be retained by the funeral director. Page 35 may be retained by the funeral director. Page 36 may be retained by the funeral director. Page 37 may be retained by the funeral director. Page 38 may be retained by the funeral director. Page 39 may be retained by the funeral director. Page 40 may be retained by the funeral director. Page 41 may be retained by the funeral director. Page 42 may be retained by the funeral director. Page 43 may be retained by the funeral director. Page 44 may be retained by the funeral director. Page 45 may be retained by the funeral director. Page 46 may be retained by the funeral director. Page 47 may be retained by the funeral director. Page 48 may be retained by the funeral director. Page 49 may be retained by the funeral director. Page 50 may be retained by the funeral director. Page 51 may be retained by the funeral director. Page 52 may be retained by the funeral director. Page 53 may be retained by the funeral director. Page 54 may be retained by the funeral director. Page 55 may be retained by the funeral director. Page 56 may be retained by the funeral director. Page 57 may be retained by the funeral director. Page 58 may be retained by the funeral director. Page 59 may be retained by the funeral director. Page 60 may be retained by the funeral director. Page 61 may be retained by the funeral director. Page 62 may be retained by the funeral director. Page 63 may be retained by the funeral director. Page 64 may be retained by the funeral director. Page 65 may be retained by the funeral director. Page 66 may be retained by the funeral director. Page 67 may be retained by the funeral director. Page 68 may be retained by the funeral director. Page 69 may be retained by the funeral director. Page 70 may be retained by the funeral director. Page 71 may be retained by the funeral director. Page 72 may be retained by the funeral director. Page 73 may be retained by the funeral director. Page 74 may be retained by the funeral director. Page 75 may be retained by the funeral director. Page 76 may be retained by the funeral director. Page 77 may be retained by the funeral director. Page 78 may be retained by the funeral director. Page 79 may be retained by the funeral director. Page 80 may be retained by the funeral director. Page 81 may be retained by the funeral director. Page 82 may be retained by the funeral director. Page 83 may be retained by the funeral director. Page 84 may be retained by the funeral director. Page 85 may be retained by the funeral director. Page 86 may be retained by the funeral director. Page 87 may be retained by the funeral director. Page 88 may be retained by the funeral director. Page 89 may be retained by the funeral director. Page 90 may be retained by the funeral director. Page 91 may be retained by the funeral director. Page 92 may be retained by the funeral director. Page 93 may be retained by the funeral director. Page 94 may be retained by the funeral director. Page 95 may be retained by the funeral director. Page 96 may be retained by the funeral director. Page 97 may be retained by the funeral director. Page 98 may be retained by the funeral director. Page 99 may be retained by the funeral director. Page 100 may be retained by the funeral director.

IMPORTANT: If item 21 is marked as "AT WORK" or "NOT WHILE AT WORK", the funeral director must obtain a copy of the death certificate from the employer or the person who was with the deceased at the time of death.

11/12/50

11/12/50
11/12/50
11/12/50

X

11/12/50

11/12/50

11/12/50

11/12/50

11/12/50

098136

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|---|---|--|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
George A. Read | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 5, 1985 | | | 2b. HOUR
8:00 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
5 10 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. 8 MONS 28 DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Dakota | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda Maryland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital Bethesda, Md. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Furniture | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
UNKNOWN | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, MONTH UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
544-03-7180 | | 17. INFORMANT ADDRESS
Josef F. Cerwonka Bethesda, Md. 20814
4710 Bethesda Ave #1319 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral aneurysm rupture</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 weeks</u>
<u>4 weeks</u>
<u>20 yrs</u> |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 19 71</u> , to <u>5 March 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN
<u>John M. Wynn</u> | | | | DEGREE
MD | | 22c. DATE SIGNED
3/6/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John M. Wynn MD | | | | 22e. ADDRESS
2001 NORFOLK Ave Bethesda, Md 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | 23b. DATE
3-6-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Med. School | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington D.C. | |
| 24. FUNERAL DIRECTOR NAME
COLUMBIA MORT. SERVICES WASHINGTON, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 08 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

MEDICAL CERTIFICATION

IMPORTANT: If item 18 is marked as injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN CRISS REAGAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 22, 1985 | | 2b. HOUR
3:25P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
NOVEMBER 14, 1940 | | 6. AGE (IN YEARS LAST BIRTHDAY)
44 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
TEXAS | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
COMPUTER PROGRAMMER | | 12b. BUSINESS OR INDUSTRY
ELECTRIC |
| 13a. STATE
D.C. | | 13b. COUNTY
NIH | 13c. CITY OR TOWN
WASHINGTON, D.C. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
319 3RD ST SE 20003 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN THOMAS REAGAN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHRISTEEN GLOVER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
460-62-4756 | | 17. INFORMANT (EXECUTOR) ADDRESS
RALPH PALMIGIANA, 1111 19TH ST., N.W., WASH., D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONITIS
DUE TO, OR AS A CONSEQUENCE OF
(b) ACQUIRED IMMUNE DEFICIENCY SYNDROME
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
<input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 30, 1984 to MARCH 22, 1985 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 22, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) XXXXX view the body after death. | | | | | |
| 22b. SIGNATURE
Stacy R Nerenstone MD | | DEGREE | | 22c. DATE SIGNED
3-23-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STACY R NERENSTONE, MD | | 22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20205 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
3/24/85 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND PG. MD. | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC.
ADDRESS
1804 T ST., N.W., WASH., D.C. 20009 | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1985 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

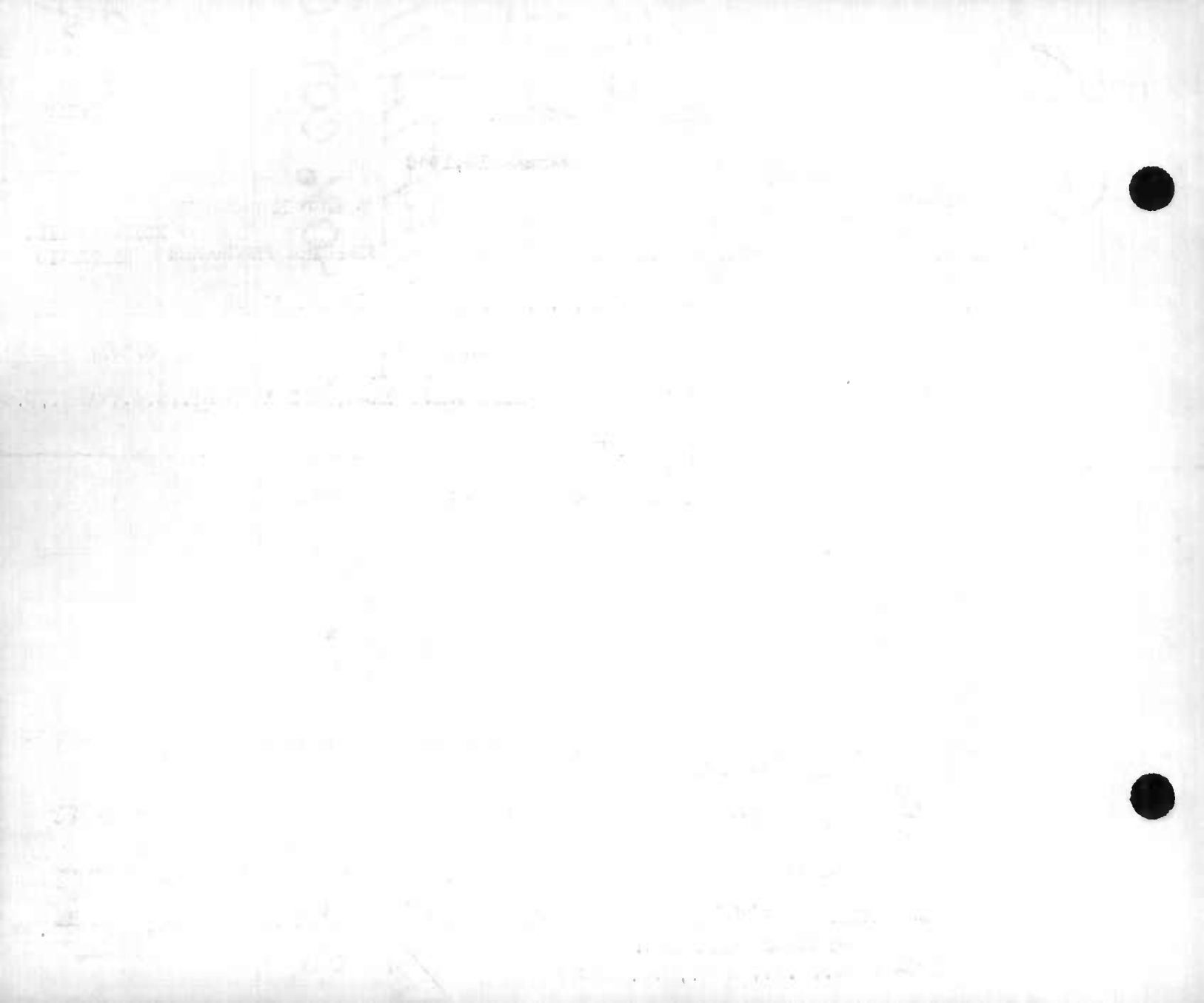
MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the registrar.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

IMPORTANT: If both 21a and 21b are marked, the medical examiner must be notified of the injury, or other traumatic event, the medical examiner must be notified of the injury, or other traumatic event, the medical examiner must be notified of the injury, or other traumatic event.



BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|---|------------------------|---|--|--|--|---|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
George Edward Reid | | | | | | 2a DATE KNOWN OF DEATH
ESTIMATED
March 2 1985 | | 2b HOUR
10:44 | | 2c DATE PRONOUNCED DEAD
March 2 1985 | |
| 3 SEX
Male | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
12 26 1916 | 6 AGE (IN YEARS)
LAST BIRTHDAY
68 | 7 IF UNDER 1 YR.
MONTHS DAYS
RS | 8 IF UNDER 24 HRS.
HOURS MIN
RS | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 10 CITY OR TOWN OF DEATH
Takoma Park | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery | | 10 CITY OR TOWN OF DEATH
Takoma Park | | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | |
| 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b KIND OF BUSINESS OR INDUSTRY
W.G.L. Company | | 13a STREET ADDRESS
6707 Wells Parkway | | 13b CITY OR TOWN
Hyattsville | | 13c INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET ADDRESS
20781 | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Earl Reid | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Evelyn Stott | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
577-09-2002A | | 17 INFORMANT
Cecile Reid (Wife) | | 17 ADDRESS
Same as 13e | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) Chronic Myocardial Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Yrs | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
None | | | | | | | | | | | |
| 19a DATE OF OPERATION
None | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers, M.D. | | TITLE (SPECIFY)
Day | | | | | | MEDICAL EXAMINER
1919 Seminary Rd. Silver Spring, Md. | | DATE SIGNED
March 2 1985 | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
3/5/85 | | 23c NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Maryland | | 25a DATE REC'D. BY REGISTRAR
MAR 7 1985 | | 25b REGISTRAR'S SIGNATURE
Wenderson-Randall | |
| 24 FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave. Hyattsville, Md. 20781 | | | | | | | | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8509007

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HELEN Rios | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-21-85 | | 2b. HOUR
9:30 A.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
2 25 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
PUERTO RICO | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
WHEATON, | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
UNIVERSITY CONV. & NURSING HOME | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SEAMSTRESS | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD | | 13b. COUNTY
MONT | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Santiago Carrero | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Marcelina Trizarro | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
065-18-3732 | | 17. INFORMANT
son
Manuel I. Rios | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
10 YEARS | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.) | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 3/1 1985 to 3/21 1985, that (i) (we) last saw the deceased alive on 3/18 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (ii) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Myron L. Lemkin | | DEGREE | | 22c. DATE SIGNED
3/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MYRON L. LEMKIN MD | | 22e. ADDRESS
2309 SHOREFIELD DR WHEATON, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Mar. 23, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Mont. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1985 | | 25b. REGISTRAR'S SIGNATURE | |
| 500 University Blvd., W. Silver Spring, Md. | | | | | |

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 3 and 4 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

088130

10-1-50

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| | | | | |
|---------|---------|---------|---------|---------|
| 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 |
| 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 |
| 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 |
| 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 | 10-1-50 |

10-1-50

093001

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lottie | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 24 85 | | | 2b. HOUR
5 20 P.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
OCT. 22, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 12. CITY OR TOWN OF DEATH
ROCKVILLE | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NURSING | | 15. KIND OF BUSINESS OR INDUSTRY
MEDICINE | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3521-ORCHARD AVE. 21207 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM -- KAUTTER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
SARAH -- SCHAPPEL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
217-01-8954 | | 17. INFORMANT
ADDRESS
REV. DR. RICHARD REICHARD- N.L.H. - ROCKVILLE, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Negative Septicemia, acute APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary Tract Infection 5 days
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION
--- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 22 , 19 80 , to March 24 , 19 85 , that (I) (we) last saw the deceased alive on March 24 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold F. M. Cann, M.D. | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-25-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. M. CANN | | | 22e. ADDRESS
3355-16th St. N.W. WASH. D.C. 20010 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3-27-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
CHRIST CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
FOUNTAIN SPRINGS, PENNA. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HYSONG CO., INC.-1300 N ST., NW WASH. DC | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
APR 02 1985 Julia Davidson-Randall | | | |

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

079040

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 09009

| | | | |
|--|-------------------------------------|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST CORA MIDDLE JACKSON LAST RITCHIE
<i>Cora JACKSON Ritchie</i> | | 2. DATE OF DEATH MONTH DAY YEAR HOUR
MARCH 12 1985 8:15 PM | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH MONTH DAY YEAR
SEPT. 1 1896 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
CONN. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | |
| 10. CITY OR TOWN OF DEATH
Olney | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
BROOKE GROVE NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
H. Wife | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | |
| 13c. CITY OR TOWN
Olney | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS
17724 Overwood Dr. 20832 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
George - Jackson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Anne - Wilson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
049-36-1426 | |
| 17. INFORMANT ADDRESS
William J. Ritchie Same as # 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCH</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>glass</i> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<i>Organic Brain Syndrome</i> | | | |
| 19a. DATE OF OPERATION
<i>3/12/85</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/15</i> 19 <i>85</i> , to <i>3/12</i> 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3/15</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) show the body after death. | | | |
| 22b. SIGNATURE <i>C. H. Barber</i> DEGREE | | 22c. DATE SIGNED <i>3/12/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>C. H. Barber</i> | | 22e. ADDRESS
<i>1814 P. P. Highway Dr., Olney MD 20832</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MARCH 18, 1985 | |
| 23c. NAME OF CEMETERY OR CREMATORY
EAST CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
MANCHESTER HARTFORD CONN. | |
| 24. FUNERAL DIRECTOR NAME
FRANCIS H. BARBER | | 25a. DATE REC'D. BY REGISTRAR
MAR 15 1985 | |
| ADDRESS
LAYTONSVILLE, MD. 20879 | | 25b. REGISTRAR'S SIGNATURE
<i>Davidson-Randall</i> | |

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove co-bonoppers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

094149

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | |
|---|--|---|---|--|---------------------|--|
| 1. DECEASED NAME
[TYPE OR PRINT]
FIRST MIDDLE LAST
RAMON RIVAS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 13, 1985 | | 2b. HOUR
6:00P M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 4, 1929 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
55 | | 7a. BIRTHPLACE
[STATE OR FOREIGN COUNTRY]
NICARAGUA | | 7b. CITIZEN OF WHAT COUNTRY?
NICARAGUA | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
[IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS]
NIH, THE CLINICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Professor | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
school | | 13a. STREET ADDRESS / ZIP CODE
-- 99999 | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JUAN JOSE RIVAS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LOLA VALDIVIA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]
NO | | |
| 16b. SOCIAL SECURITY NO.
N/A | | 17. ADDRESS
6201 Long Meadow Rd, McLean, Virginia
Mrs. Lolita E. Campagne (Sister) 22101 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

RESPIRATORY FAILURE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

PROBABLE SEPSIS, HEPATIC EARLY ABCESESSES

DUE TO, OR AS A CONSEQUENCE OF

LYMPHOMA, NODULAR HISTIOCYTIC

2 YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 25, 19 81 to MARCH 13, 19 85, that (x) (we) last saw the deceased alive on MARCH 13, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (do) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Mark Levitt MD | | | | 22c. DATE SIGNED
3/14/85 | | 22d. ADDRESS
NATIONAL INSTITUTES OF HEALTH, 9000
ROCKVILLE PIKE, BETHESDA, MARYLAND 20205 | |

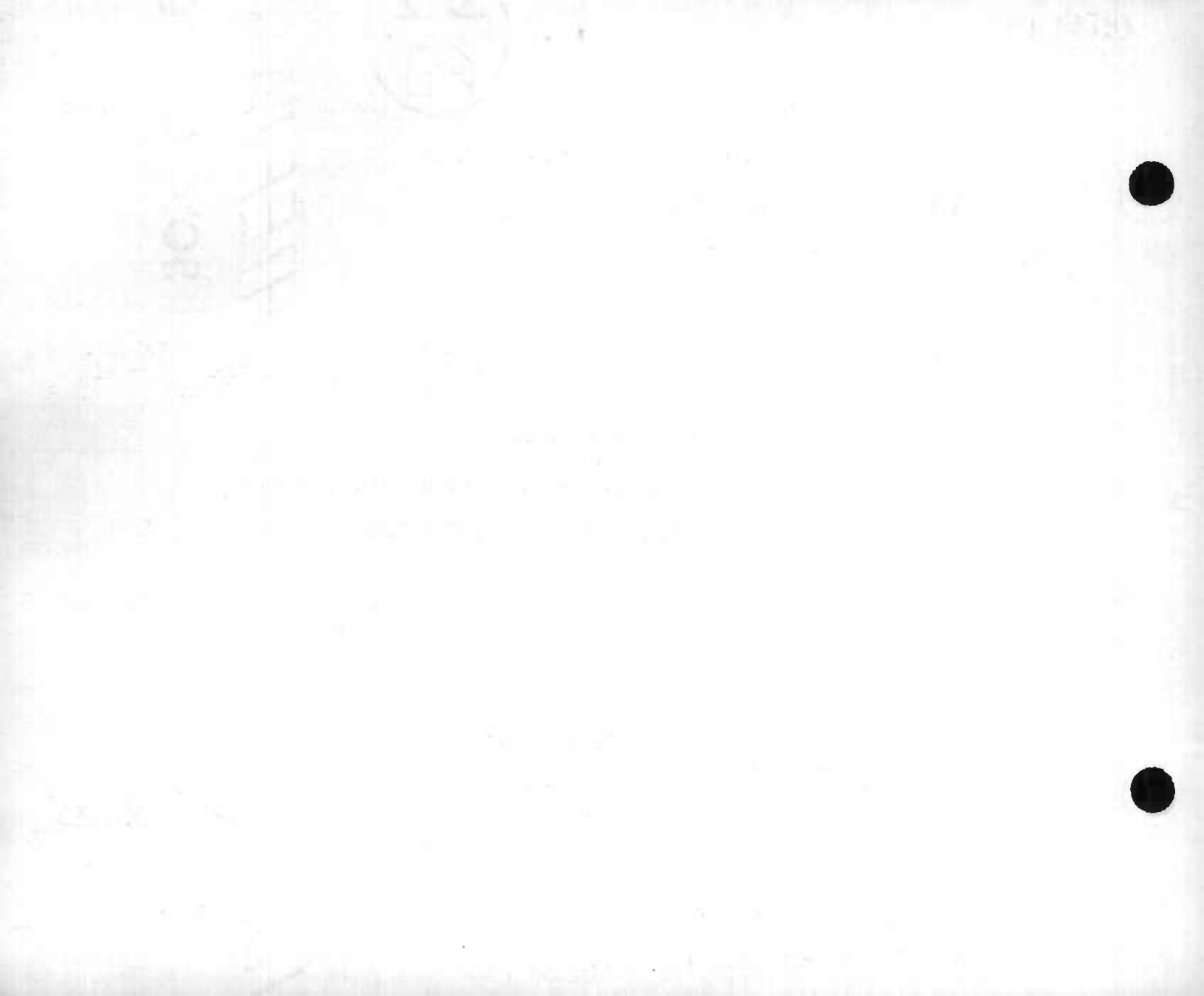
| | | | | | | | |
|---|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | 23b. DATE
3-18-85 | | 23c. NAME OF CEMETERY OR CREMATORY
NUBIA VACA | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Managua, Nicaragua | |
| 24. FUNERAL DIRECTOR
Marshall's Funeral Home, Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 22 1985 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corroborating pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to certify.



093077

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 1 1

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen H Robinson | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/22/85 | | | 2b. HOUR
3:00 AM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 24, 1908 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery CO MD. | | | |
| 11. CITY OR TOWN OF DEATH
Bethesda Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Woodward and Lothrop | |
| 13a. STATE
Virginia | | 13b. COUNTY
Culpeper | | 13c. CITY OR TOWN
Culpeper | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
RFD 2, Box 237-A 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Otto Hancock | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Nolan | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | |
| 16b. SOCIAL SECURITY NO.
224-24-2893 | | | 17. INFORMANT
Stuart N. Caldwell | | | ADDRESS RFD 2, Box 237-A
Culpeper, VA 22701 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>Cerebral infarct</u>
DUE TO, OR AS A CONSEQUENCE OF (b). <u>Multiple Aneurysms including CWS</u>
DUE TO, OR AS A CONSEQUENCE OF (c). <u>Severe thrombocytopenia</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 week</u>
<u>1 week</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a
<u>Acid Phos & Chronic Myocardial Ischemia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1970</u> , 19 <u>70</u> , to <u>March 22</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>W. L. An Killay</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>March 22, 1985</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William Killay | | | 22e. ADDRESS
8218 Wisconsin Ave., Bethesda, MD 20814 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3-25-85 | | 23c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Culpeper VA | | | |
| 24. FUNERAL DIRECTOR
NAME
C/O Re Funeral Home J Brown | | | ADDRESS
P. O. Box 90
Culpeper, VA | | 25a. DATE REC'D. BY REGISTRAR
MAR 27 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Rodell</u> | | |

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MAR 2 1961

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 1 2

REG. NO.

106182

| | | | | | | | | | | | |
|---|--|--|--|---|-----------------------|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Wilbur H. Rock | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 3, 1985 | | 2b. HOUR
9:10 P.M. | | | | | | |
| 3. SEX
Male | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
AUGUST 25, 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS | | 7b. UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
POSTAL SUPERVISOR | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | | | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
14212 ARCTIC AVENUE 20853 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILBUR HOPKINS ROCK | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARY EVA BOND | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
YES WW II | | | | 16b. SOCIAL SECURITY NO.
578-22-4565 | | 17. INFORMANT
ADDRESS
KATHRYN L. ROCK SAME AS 13 WIFE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>sustained ventricular tachycardia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>severe cardiomyopathy</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic alcohol consumption - inactive</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
hours
months
years | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>3/2</u> , 19 <u>85</u> , to <u>3/3</u> , 19 <u>85</u> , that (we) lost
saw the deceased alive on <u>3/3</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Roger F. Leonard</u> | | | | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/20/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Roger F. Leonard | | | | 22e. ADDRESS
10401 Old Georgetown Rd, Bethesda MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | | 23b. DATE
3/7/85 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SUITLAND PRI. GEO. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MAR 2 1982 8 08 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR Edith L. . | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Edith L. Rodgers | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR 3/3/85 | | | 2b. HOUR
10⁴⁵ PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR July 20 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Restaurateur | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Business | |
| 13a. STATE
M D | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Kensington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
3511 Frederick Pl. 20895 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Campbell | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Quileya Jean Lawhorn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
578-26-0229 | | 17. INFORMANT ADDRESS
Eunice E. Shadle (Dau.) Springfield, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiovascular failure
DUE TO, OR AS A CONSEQUENCE OF
(b) myocardial infarction involving R.V.
DUE TO, OR AS A CONSEQUENCE OF
(c) cardiac renal, endocrine system | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/3/85 , 19 85 , to 3/3 , 19 85 , that (I) (we) last saw the deceased alive on 3/3 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Georina | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3/3/1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Wilhelmina CAMINA MD | | | | 22e. ADDRESS
4912 ADRIAN ST
ROCKVILLE, MD 20853 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
March 7, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Prince Geo. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME Joseph Gawler's Sons 5130 Wisc. Ave. N.W. Washington, D.C. | | | | | | | | | |

Robert L. Rogers

White
XXXXX

Female

July

20 1897

xx

U.S.A.

Virginia

Secretary

22892

x

Montgomery

M.D.

Campbell

Orleans

Jean

Lamborn

6007 Brandon v.

278-6-0229 Prince F. Shadle (Dan.) Springfield, Va.

2/3/1987

Burial March 7, 1987 Ft. Lincoln Cemetery Brentwood Prince Geo. Md.

Joseph Gawler's Sons 2100 Dec. Ave. N.E.
Washington, D.C.

REG. NO.

MEDICAL CERTIFICATION

BP

034051

20X2001 CM FIBER

DAVEY LAM DONKE



ROBERT E. GILBERT, JR.

0860061

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9015

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Ana Rodriguez | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/14/85 | | 2b. HOUR
130 AM | |
| 3. SEX
Female | 4. RACE
Hispanic | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 26, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Puerto Rico | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery Co., MD. | |
| 10. CITY OR TOWN OF DEATH
Tacoma Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Washington Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home |
| 13a. STATE
Virginia | | 13b. COUNTY
Arlington | 13c. CITY OR TOWN
n/a | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Flores | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Juana Rodriguez | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
581-24-1351A | | 17. INFORMANT
ADDRESS
Dominga Colon (daughter) same as 13 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac and respiratory arrest.

DUE TO, OR AS A CONSEQUENCE OF

(b) Dehydration

DUE TO, OR AS A CONSEQUENCE OF

(c) Adult onset diabetes

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | | | |
|--|--|--|--|--|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/12/85</u> 19 <u>85</u> to <u>3/14/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/14/85</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Smith Ho</u> | | | | 22c. DATE SIGNED
3/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SMITH HO | | | | 22e. ADDRESS
7610 Carroll Ave Tacoma Park Md. | |

| | | | |
|--|------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
17 Mar 85 | 23c. NAME OF CEMETERY OR CREMATORY
Juncos Cemetery | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Juncos, Puerto Rico |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
David L. Sauers Funeral Home, Falls Church, VA | | 25a. DATE REC'D. BY REGISTRAR
MAR 21 1985 | 25b. REGISTRAR'S SIGNATURE
<u>John L. Anderson</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 09016 | |
|---|--|----------------------|--|--|--|--|--|--|--|-----------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) DONNY LEE ROGERS | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3-2-85 | | 2b. HOUR 8:05a | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH
DAY MONTH YEAR DEC. 1, 1984 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3 1 | | 7c. DATE PRONOUNCED DEAD 3-2-85 | | 7d. HOUR 8:05a | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Olney, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH ROCKVILLE | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE | | | |
| 13a. STATE MD. | | | | 13b. COUNTY MONTGOMERY | | | | 13c. CITY OR TOWN DICKERSON | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Edward C. Rogers, Jr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Patricia Mowell | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) no | | | |
| 16b. SOCIAL SECURITY NO. None | | | | 17. INFORMANT ADDRESS Edward C. Rogers, Jr. Same as # 13 | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
7980 Sudden infant death syndrome
IMMEDIATE CAUSE (a) 7980
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
(c) _____ | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Margie McGhee | | | | TITLE (SPECIFY) M.D. Assistant | | | | DATE SIGNED 3-4-85 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | | 23b. DATE March 5, 1985 | | | | 23c. NAME OF CEMETERY OR CREMATORY Prospect Cemetery | | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE Mt. Airy Frederick Md. | | | | 24. FUNERAL DIRECTOR
NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | | | 25a. DATE REC'D. BY REGISTRAR MAR 08 1985 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 1 7

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Helen Gaska Rohan | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 2, 1985 | | | 2b. HOUR
10:55am | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 25, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF ANY IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Center | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Germantown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS / ZIP CODE
20874 | | | 13f. STREET ADDRESS / ZIP CODE
13146 Country Ridge Drive | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Casmir Gaska | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pauline (not available) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
062-28-6300 | | 17. INFORMANT
ADDRESS
Patricia R. Fazio, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic Renal Failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Nephritis
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Ischemic Heart Disease, Atrial Fibrillation, Breast Cancer, Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/14 19 84 to 3/2 19 85 , that (I) (we) last saw the deceased alive on 3/2/85 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.) | | | | | | | | | |
| 22b. SIGNATURE
D. Shumaker, MD | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/2/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DOUGLAS R. SHUMAKER, MD | | 22e. ADDRESS
615 W. MONTGOMERY AVE
ROCKVILLE, MD 20850 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
March 6, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Most Holy Redeemer Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Schenectady, New York | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 8 1985 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Lola Davidson-Rendall | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of death.

IMPORTANT: If item 21 is marked, item 21 should not be signed, and the medical examiner must be notified.

BP



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Liberio T. Rota | | | 2a. DATE OF DEATH
MONTH DAY YEAR
03 09 85 | | | 2b. HOUR
2:30 AM | | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 20, 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS | | 7. UNDER 1 YEAR
MONTHS DAYS
00 00 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SUBURBAN | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Banquet Captain Hilton Hotel | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
10911 Bucknell Dr., 20902 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Christopher Rota | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dominica Purello | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
yes 1944-1946 | | | 16b. SOCIAL SECURITY NO.
150-07-9074 | | 17. INFORMANT
ADDRESS
Anne H. Rota Same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CANDIDIASIS
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC MYELOGENOUS LEUKEMIA
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 weeks
2 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 03, 1985 to 3-6, 1985 , that (II) (we) last saw the deceased alive on 3-6, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Richard H. Pollen | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3-10-85 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
RICHARD H. POLLEN | | | 22e. ADDRESS
10900 Greenview Ave Kensington MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Mar. 12, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis J. Collins | | | | | ADDRESS
500 University Blvd. W., Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 13 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | |
|--|--|--|--|--|--|--|--|--|--|---|--|-------------------------|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) EMMA L. ROTHWELL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 3-1-85 | | 2b. HOUR 1345 M. |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY Labor Union | | | | |
| 13a. STATE Md. | | | | 13b. COUNTY Mont. | | 13c. CITY OR TOWN Germantown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 13915 Berryville Road 20874 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George A. Jennings | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Jennings | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 578-03-0276 | | 17. INFORMANT ADDRESS Nancy L. Heil Same as # 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Aspiration, food
DUE TO, OR AS A CONSEQUENCE OF (c) Severe weakness
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
7 days | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Cylindroma, Basaloid, Cystic, Congenital, etc. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-25 , 19 85 , to 3-1-85 , 19 85 , that (I) (we) lost saw the deceased alive on 2-25-85 , 19 85 , and that in [my] (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE William H. Killay | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 3-1-85 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM H. KILLAY, M. D. | | | | 22e. ADDRESS Bethesda, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE March 4, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY Nat'l Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH FAIRFAX Va. | | | | |
| 24. FUNERAL DIRECTOR NAME Francis H. Barber ADDRESS Laytonsville, Md. 20879 | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 06 1985 25b. REGISTRAR'S SIGNATURE John Anderson | | | | | | |

BP

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1094062

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
BELLA | | | 2a. DATE OF DEATH
MARCH 31 21 1985 10:53 PM | | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
JUNE 6/02/1903 | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 10. CITY OR TOWN OF DEATH
SILVERSPRING, MD | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
MARYLAND | 13b. CITY OR TOWN
MONTGOMERY | 13c. CITY OR TOWN
ROCKVILLE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
MAX | 15. MOTHER'S MAIDEN NAME
HANNAH | | 16. STREET ADDRESS / ZIP CODE
263 CONGRESSIONAL LANE --20852-- | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO | 16b. SOCIAL SECURITY NO.
577-10-6398B | 17. INFORMANT
SAMUEL RUDO, 263 CONGRESSIONAL LANE, ROCKVILLE, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 84 to 3/21 19 85, that (I) (we) last saw the deceased alive on 3/20/1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Joel Goetz | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joel Goetz | | 22e. ADDRESS
4701 RANDOLPH RD Rockville MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | 23b. DATE
3/24/1985 | 23c. NAME OF CEMETERY OR CREMATORY
JUDEAN MEMORIAL GARDENS | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
OLNEY, MONTGOMERY, MARYLAND | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | 25a. DATE REC'D. BY REGISTRAR
MAR 28 1985 | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

BP

088086

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Margaret E. Rupertus | | | 2a. DATE OF DEATH
MONTH 3 DAY 14 YEAR 85 | | 2b. HOUR
5:30 am |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH Jan. DAY 18, YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
National Lutheran Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY
at home. |
| 13a. STATE
Maryland | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
199 Rollins Avenue 20852 | |
| 14. FATHER'S NAME
FIRST Charles MIDDLE LAST Diller | | | 15. MOTHER'S MAIDEN NAME
FIRST Mollie MIDDLE LAST Bachhausen | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
577-50-2407 | | 17. INFORMANT
ADDRESS Mr. William H. Clarke #5 N. Adams St. Rockville, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Bronchitis, acute**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 daysPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Alzheimer's Disease; Urinary tract infection.**19a. DATE OF OPERATION
Dec 29, 197819b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Urinary tract infection20a. AUTOPSY?
YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that (I) (this hospital) attended the deceased from **Dec 29, 1978** to **March 14, 1985**, that (I) (we) **Not** saw the deceased alive on **March 13, 1985**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.22b. SIGNATURE
Harold F. McCannDEGREE
M.D.ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐22c. DATE SIGNED
3-14-8522d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN22e. ADDRESS
3155-16th St. N.W. WASH DC. 2001023a. BURIAL, CREMATION, REMOVAL
(SPECIFY) **burial**23b. DATE
March 18, 198523c. NAME OF CEMETERY OR CREMATORY
George Washington Cemetery23d. LOCATION
CITY OR TOWN COUNTY STATE
Hyattsville, Maryland24. FUNERAL DIRECTOR
NAMEADDRESS
The Hysong Co. 1300 N St. N.W. Washington, D.C.25a. DATE REC'D. BY REGISTRAR
MAR 22 198525b. REGISTRAR'S SIGNATURE
J. Davidson-Rodriguez

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 1

1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject. The second part of the report is a description of the methods used in the study. This is followed by a presentation of the results of the study. The final part of the report is a discussion of the results and their implications.

The results of the study show that there is a significant relationship between the variables studied. This relationship is consistent across all of the groups studied. The implications of these findings are discussed in the final part of the report. It is suggested that further research be conducted in this area to clarify the relationship between the variables studied.

The study was conducted by the Department of Psychology, University of California, Los Angeles. The results of the study are presented in the report. The report is available for purchase from the University of California Press.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner is required to be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Lillian R. Ruppert | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 14 1985 | | | 2b. HOUR
10:45 PM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 16, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairland Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET ADDRESS
8505 Springvale Rd. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edwin A. Roper | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lillian T. Dorsey | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
N/A | | 17. INFORMANT
Jane Johnson | | ADDRESS
5712 Stilwell Rd., Rockville, Md. 20851 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis heart disease
DUE TO, OR AS A CONSEQUENCE OF (c) Stroke
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from November 19 83 to 3-14 85 , that (I) (we) lost saw the deceased alive on 2-26 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Jason P. Geiger, Md. | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3-15 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jason P. Geiger, Md. | | 22e. ADDRESS
8830 Cameron St. Suite 503 Silver Spring, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
cremation | | 23b. DATE
Mar. 16, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes, Arlington, VA. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1985 | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Evelyn Kirkwood Saddle | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 9, 1985 | | | 2b. HOUR
6:42 PM | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 01 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SCOTLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery CO. MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | |
| 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 13. STREET ADDRESS / ZIP CODE
1135 Univ Blvd West 20902 | | 14. FATHER'S NAME
FIRST MIDDLE LAST
ROBERT KIRKWOOD | | | | | |
| 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELEN HOSIE | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) ----- | | | | | |
| 16b. SOCIAL SECURITY NO.
288-14-6797 | | 17. INFORMANT
ADDRESS
CAROL BRYANT 10101 PIERCE DR., SIL. SPR., Md. 20901 | | | | | |

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Emphysema

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from <u>2</u> 19 <u>84</u> , to <u>3/9</u> 19 <u>85</u> , that (ii) (we) last
saw the deceased alive on <u>2</u> 19 <u>85</u> , and that in (iii) (our) opinion death occurred on the date and hour and from the causes stated
above. (ii) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Jay Weimer</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jay Weimer | | 22e. ADDRESS
4701 Randolph Rd Rockville, Md 20852 | | | | | |

| | | | | | | | |
|---|--|------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
3-10-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE, P.G.C. Md. | |
| 24. FUNERAL DIRECTOR
NAME
W. W. CHAMBERS CO. INC. ADDRESS
SILVER SPRING, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 12 1985 | | 25b. REGISTRAR'S SIGNATURE
<u>Jane Davidson</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

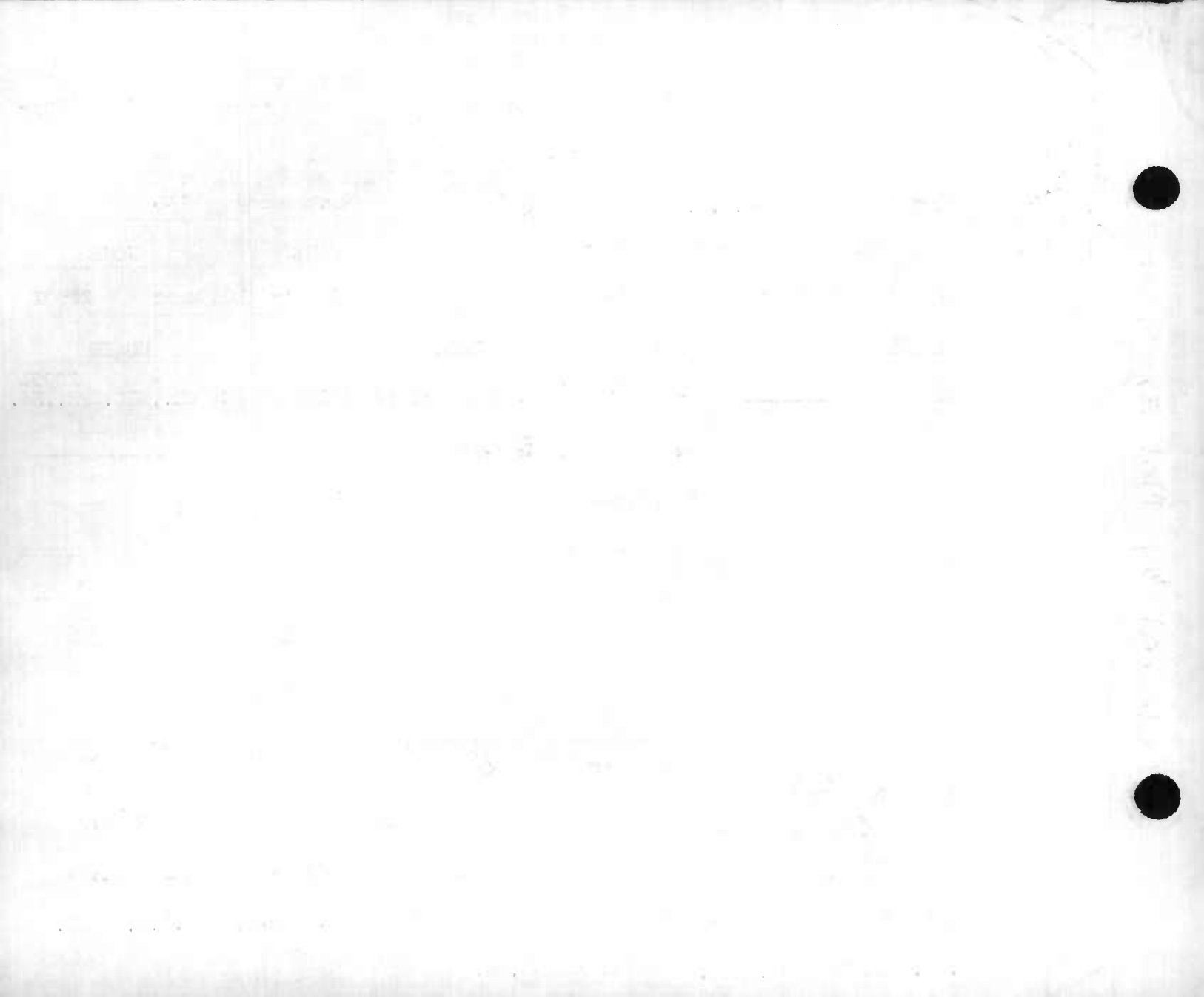
Cleared by Med Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work" in any injury, or other traumatic event, the medical examiner must be notified at the time of death.

BP



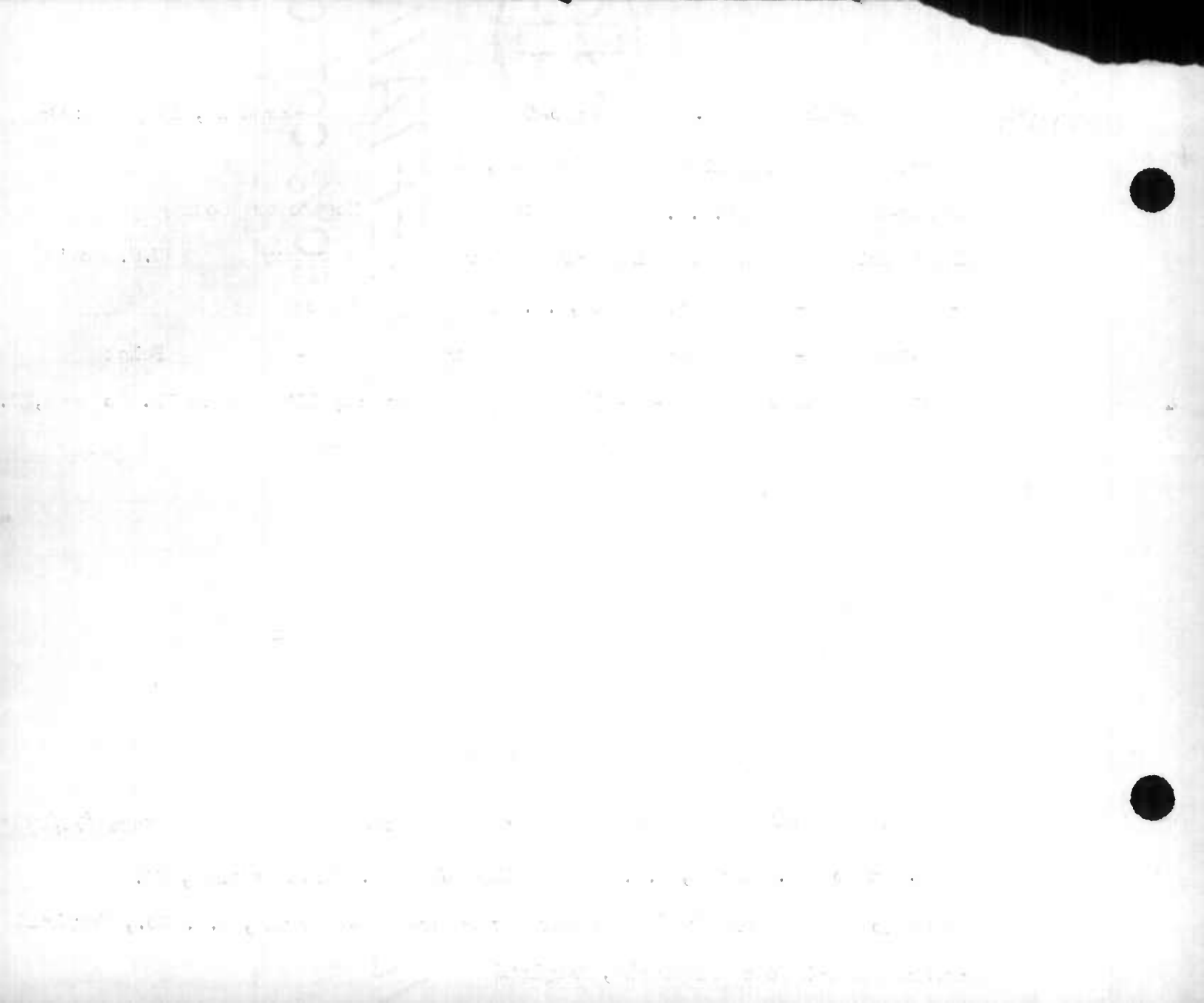
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Maria T. Samowich | | 2a. DATE OF DEATH MONTH DAY YEAR
March 18, 1985 | |
| 3. SEX
Female | | 2b. HOUR
8:00am | |
| 4. RACE
White | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
78 | |
| 5. DATE OF BIRTH MONTH DAY YEAR
May 18, 1906 | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Bel Pre Health Care Center | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't/ | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE COUNTY
- - | | 13c. CITY OR TOWN
Washington, D.C. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph - Tkach | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary - Pelak | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
055-14-2348 | |
| 17. INFORMANT ADDRESS
Stephen Cherewaty 11209 Angus Pl. Potomac, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | |
| 19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK
21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/8/83</u> 19____ to <u>3/18/85</u> 19____ that (I) (we) lost saw the deceased alive on <u>3/13/82</u> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.)
22b. SIGNATURE DEGREE
22c. DATE SIGNED
March/18/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Raymond T. Benack, M.D.
22e. ADDRESS
4115 Colie Dr. Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation
23b. DATE
March/20/85
23c. NAME OF CEMETERY OR CREMATORY
Chambers Crematory
23d. LOCATION CITY OR TOWN COUNTY STATE
Riverdale, P.G. Co., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Chambers Funeral Home Riverdale, Maryland
25a. DATE REC'D. BY REGISTRAR
MAR 22 1985
25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - in 24 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before removal.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|---|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) AGNES D SANDS | | | 2a DATE OF DEATH MONTH DAY YEAR
3-14-1985 | | 2b HOUR
12 P _M |
| 3 SEX
Fem | 4 RACE
White | 5 DATE OF BIRTH
MONTH DAY YEAR
6 4 08 | | 6 AGE (IN YEARS LAST BIRTHDAY)
76 YRS | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE
Maryland | | | 13b COUNTY
Montgomery | 13c CITY OR TOWN
Bethesda | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John Dillman | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Eytche | | 13e STREET ADDRESS / ZIP CODE
8803 Grant Street 20834 | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
578-38-5249 | | 17 INFORMANT
Daughter ADDRESS
4025 Bryd Road | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
6/1 19 85 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
84 3/14 85 | | |
| 22a I certify that (I) (this hospital) attended the deceased from 3/14 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mark H. Egan | | DEGREE | | 22c. DATE SIGNED
3/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Mark H. Egan | | 22e. ADDRESS
9801 Boyette Silver Spring Md | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Mar. 16, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Silver Spring Montgomery Md. | | |
| 24. FUNERAL DIRECTOR
NAME Francis J. Collins ADDRESS
500 University Boulevard, W. Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 18 1985 | | 25b. REGISTRAR'S SIGNATURE
Jella Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 2 6

REG. NO.

| | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) THEODORE F. SAWYER | | | 2a. DATE OF DEATH
MONTH 3 DAY 18 YEAR 85 | | | 2b. HOUR
7:45AM | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH SEPT. DAY 7 YEAR 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
SOUTH CAROLINA | | 9b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TECHNICAL WRITER | | 12b. KIND OF BUSINESS OR INDUSTRY
AEROSPACE | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE VIRGINIA 13b. COUNTY SPOTSYLVANIA 13c. CITY OR TOWN SPOTSYLVANIA | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
RT. 5 959 ENGLEMAN LA. 22653 | | | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST BESSIE MIDDLE LAST HUGHES | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
1951-1955 534-32-9306 | | 17. INFORMANT
ESTHER SAWYER ADDRESS RT. 5 959 ENGLEMAN LA. SPOTSYLVANIA VA. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Diffuse B. Cerebral Interstitial pneumonia
DUE TO, OR AS A CONSEQUENCE OF:
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Coronary artery disease, Coma, H | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19
P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20/85 to 3/18/85 , that (I) (we) last saw the deceased alive on 3/17/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
A. A. Chacko | | | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. A. CHACKO | | | | 22e. ADDRESS
8500, 16th st. Suite G31, Silver Spring, MD 20910 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
CREMATION | | | | 23b. DATE
3-21-85 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN ALEXANDRIA COUNTY VA. STATE | | | |
| 24. FUNERAL DIRECTOR
NAME WILSON SMITH FUNERAL HOME ADDRESS FREDERICKSBURG | | | | | | 25a. DATE REC'D. BY REGISTRAR MAR 27 1985 25b. REGISTRAR'S SIGNATURE John T. R. R. R. | | | | | |

MEDICAL CERTIFICATION

10000



MAR 27 1968

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#5, C per FH 9/4/85 km
1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 5 0 9 0 2 7

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Leopoldina Schiller | | | 2a. DATE OF DEATH
MONTH 3 DAY 31 YEAR 85 | | | 2b. HOUR
4:10 PM | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 11 DAY 7 YEAR 1887 | | 6. AGE (IN YEARS LAST BIRTHDAY)
97 YRS | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 8. IF UNDER 24 HRS
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Yugoslavia | | 7b. CITIZEN OF WHAT COUNTRY?
Stateless | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Hebrew Home | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
MD | | | 13b. CITY OR TOWN
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
6121 montrose Rd / 20852 | | |
| 14. FATHER'S NAME
FIRST Moses MIDDLE Rosenberger LAST Kathy | | | | 15. MOTHER'S MAIDEN NAME
FIRST Kathy MIDDLE Fuchs LAST Fuchs | | | | 16. ADDRESS
Washington, D.C. 20016 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
068-28-0302 | | 17. INFORMANT
Fred Schiller; 4201 Cathedral Avenue, N.W., #101 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Sepsis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/31 19 85 to 3/31 19 85 , that (I) (we) lost
saw the deceased alive on 3/31 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I/we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Peter Sherer MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/1/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Peter Sherer MD | | | | | | 22e. ADDRESS
3947 Ferrara Dr. Wheaton MD 20906 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
4/2/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Lebanon Cemetery | | | 23d. LOCATION
CITY OR TOWN Adelphi; Prince George's; Md. COUNTY Md. STATE Md. | | | |
| 24. FUNERAL DIRECTOR
NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE
APR 03 1985 | | |
| 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

101029

LIBEL

LIBEL

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09028

REG. NO.

| | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Elmer Lawrence Schlette | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 3 DAY 14 YEAR 1985 | | | | 7b. HOUR 9:30 P.M. | |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH
MONTH 8 DAY 2 YEAR 27 | 6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN | 2c. DATE PRONOUNCED DEAD 3 MONTH 14 DAY 85 YEAR 19 | 7d. HOUR 9:30 P.M. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD. | | | | |
| 10. CITY OR TOWN OF DEATH Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 322 West Deer Park Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 322 West Deer Park Drive | | 20877 | |
| 13a. STATE Maryland | 13b. COUNTY Montgomery | 13c. CITY OR TOWN Gaithersburg | | 15. MOTHER'S MAIDEN NAME
FIRST Adele MIDDLE Heuterl LAST Heuterl | | 17. INFORMANT Wife ADDRESS 107 Saint Lucia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 14. FATHER'S NAME
FIRST Oscar MIDDLE Conrad LAST Schlette | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. 494-26-5668 | | 17. INFORMANT Barbara Jean Schlette ADDRESS Lout East | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. crisis of the liver.
(b) crisis of the liver.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE John Tauber M.D. | | | | TITLE (SPECIFY) Daguth MEDICAL EXAMINER | | DATE SIGNED 3-14-85 | | Baltimore, Md. | |
| EXAMINER'S NAME (TYPE OR PRINT) John Tauber | | | | ADDRESS 8218 Wisconsin Ave | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE March 20, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY Quantico National Cemetery | | | | 23d. LOCATION
CITY OR TOWN Quantico COUNTY Virginia STATE | |
| 24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Home, P.A. Rockville, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR MAR 20 1985 | | 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | |

BP
DHMH - 17
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

021120

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MAY 10 1960
U.S. AIR FORCE



MAILED

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APR 25 11 2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 09029

FOR
1 - STATE
REGISTRAR

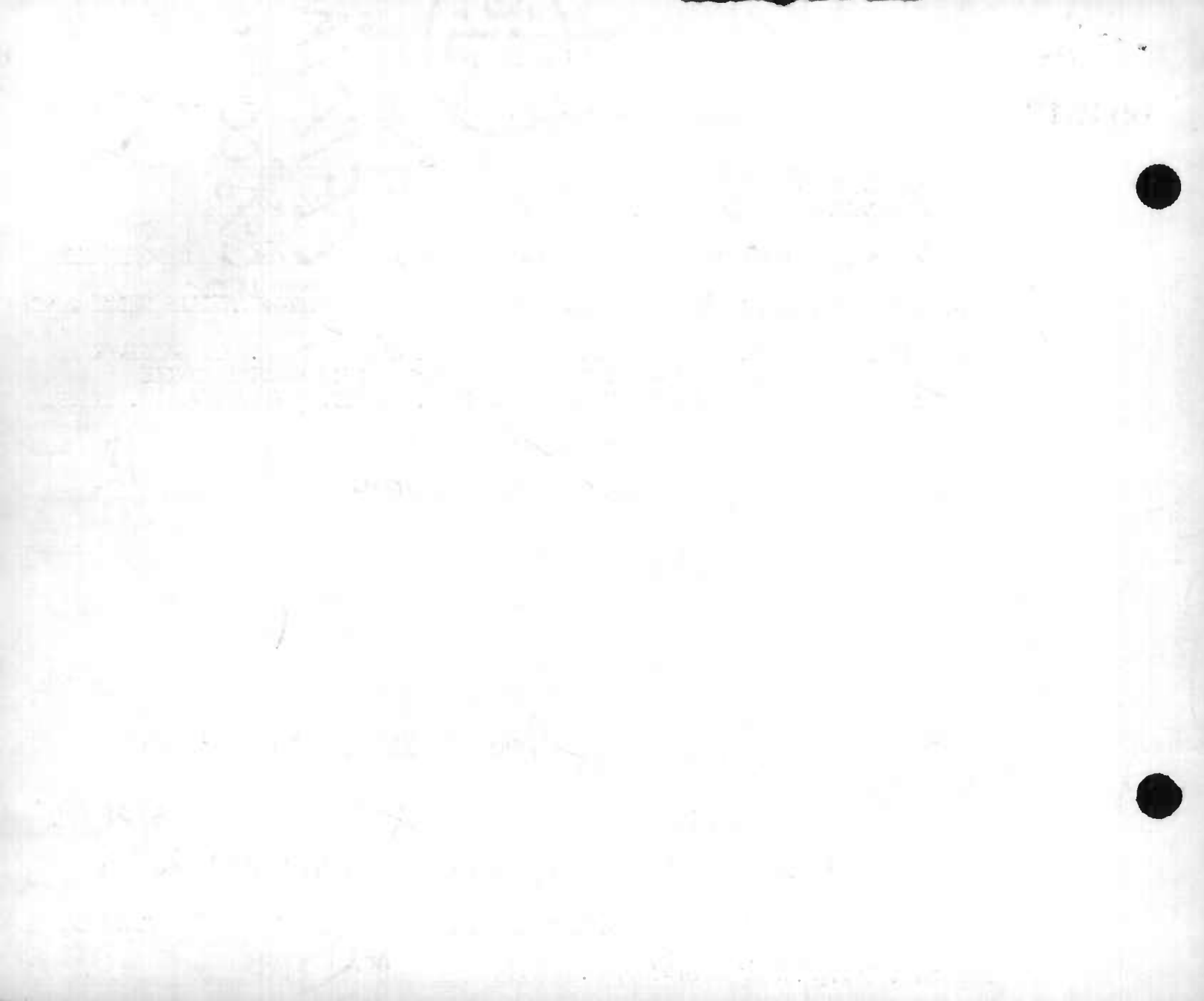
REG. NO.

| | | | | | | | | |
|---|---------------------|---|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Elizabeth GARDINER Schmidt</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 26 85</i> | | | 2b. HOUR
<i>4:10 AM</i> | | |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1 19 15</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>70</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | 8. IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (COUNTRY)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Mont.</i> | | MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>Mont.</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hosp</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>RETIRED</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>HOMEMAKER</i> | |
| 13a. STATE
<i>MARYLAND</i> | | | 13b. COUNTY
<i>MONTGOMERY</i> | | 13c. CITY OR TOWN
<i>SILVER SPRING</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>EDWIN M. GARDINER</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>IDA L. GARDINER</i> | | 13e. STREET ADDRESS / ZIP CODE
<i>206 GRANVILLE DRIVE 20901</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | | 16b. SOCIAL SECURITY NO.
<i>578-14-3635</i> | | 17. INFORMANT
NAME ADDRESS
<i>EDWIN A. SCHMIDT ANNANDALE, VA. 22003</i> | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic adenocarcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
Approximate interval between onset and death: (a) <i>1h</i> , (b) <i>1hr.</i> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>None</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that: (i) (this hospital) attended the deceased from <i>March 25 85</i> to <i>March 25 85</i> , that (ii) (we) lost saw the deceased alive on <i>March 25 85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<i>Martin D. Wultz</i> | | | DEGREE
<i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/26/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>MARTIN WULTZ</i> | | | 22e. ADDRESS
<i>Greenway CT RR Greenbelt MD 20770</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>BURIAL</i> | | | 23b. DATE
<i>3/29/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>ARLINGTON NATIONAL</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>ARLINGTON VIRGINIA</i> | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i> | | | | | 25a. DATE REC'D BY REGISTRAR
<i>APR 1 1985</i> | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randell</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



088133

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

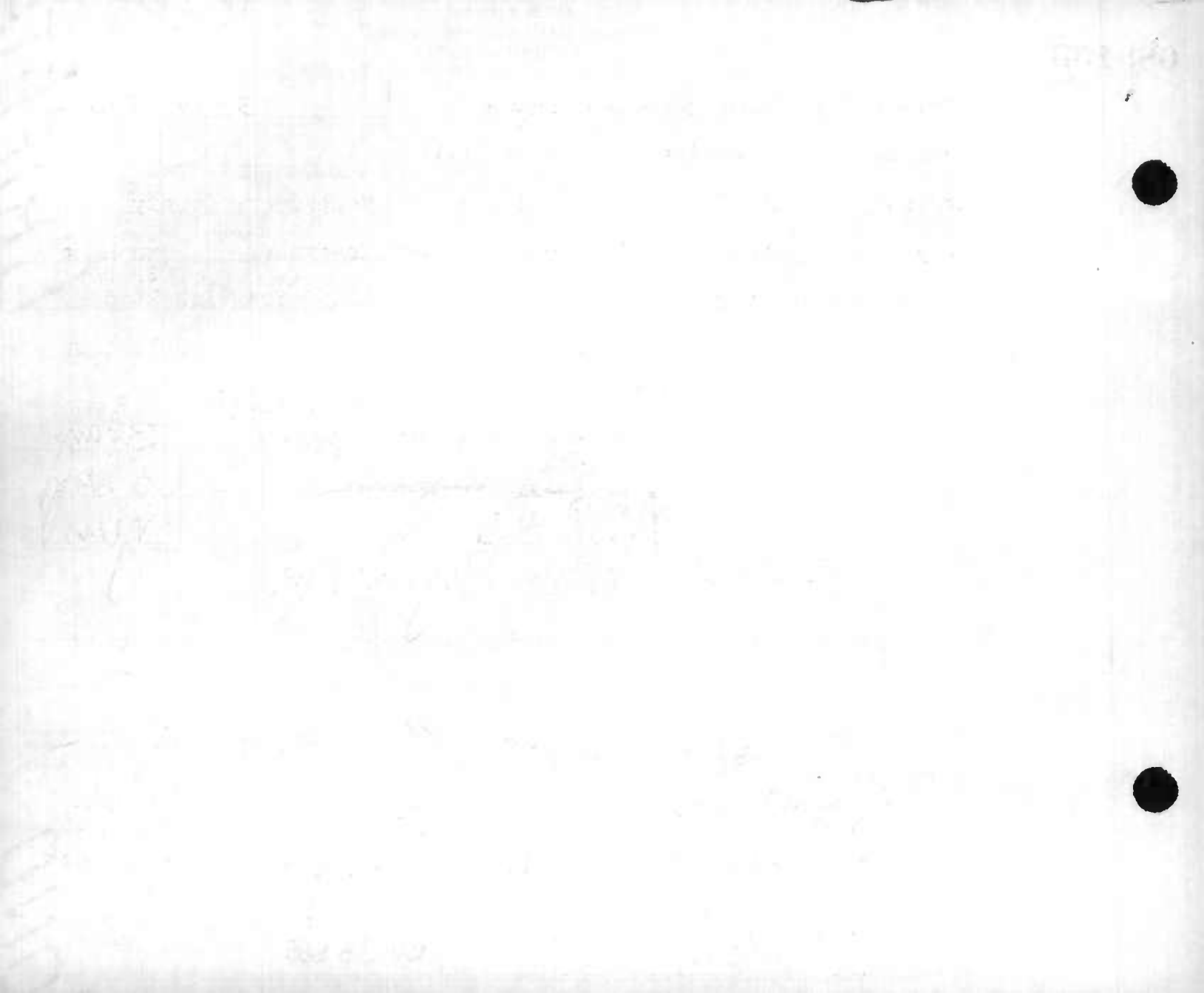
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SARAH ELIZABETH SCHWARTZBECK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-19-85 | | | 2b. HOUR
5:12 AM | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 17, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sharon Nursing Home | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
20850
13850 Travilah Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Roberts | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Robertson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17. INFORMANT (Daughter) ADDRESS
21110 New
Joyce Villella Hampshire Ave,
Brookeville MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Congestive Heart Failure
5 days
years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Organic Brain Syndrome | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/19/85 to 3/19/85, that (I) (we) last saw the deceased alive on 3/19/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | |
| 22b. SIGNATURE
C. H. L. [Signature] | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/19/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
C. H. L. [Signature] | | | 22e. ADDRESS
1914 P. P. Highway Dr., Olney MD 20832 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
March 23, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Maryland | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland | | | | | 25. DATE REC'D. BY REGISTRAR
MAR 26 1985 REGISTRAR'S SIGNATURE
John Davidson | | | | |



O HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|--|--|--|--|--|---|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MATTIE L MIDDLE SCOTT LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR
3-14-85 | | 2b. HOUR
8:35 AM |
| 3. SEX
FEMALE | 4. RACE
BLACK | 5. DATE OF BIRTH
May 27, 1904
3 27 04 | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GEORGIA | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | |
| 10. CITY OR TOWN OF DEATH
MONTGOMERY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HOLY CROSS HOSP. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic |
| 13a. STATE
WASHINGTON DC DISTRICT OF COLUMBIA | | 13b. CITY OR TOWN
WASHINGTON DC | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST (unknown) MIDDLE LAST Holloway | | 15. MOTHER'S MAIDEN NAME FIRST Pearl MIDDLE Buckner LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
579-D-8014 | | 17. INFORMANT (Son) 11 Logan Circle NW (20005)
Elder James A. Scott | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pleural Effusion</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-14-85</u> to <u>March 14, 1985</u> , that (I) (we) last saw the deceased alive on <u>3-14-85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Robert Boxbaum</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/14/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert Boxbaum, M.D. | | 22e. ADDRESS
10313 Georgia Ave S.E. Land. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
03/19/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | |
| 23d. LOCATION CITY OR TOWN
Arlington, Virginia | | 23e. DATE REC'D. BY REGISTRAR (SIGNATURE)
MAR 18 1985 | | | |
| 24. FUNERAL DIRECTOR NAME LATNEY's Funeral Home ADDRESS 3831 Ga. Ave. NW; Washington, DC 20011 | | | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 3 2

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BETTY WADE SCRUGGS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 20, 1985 | | 2b. HOUR
12:45 AM |
| 3. SEX
FEMALE | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 9, 1953 | | 6. AGE (IN YEARS LAST BIRTHDAY)
31 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
210 DOMER AVENUE | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN TAKOMA PARK | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
KENNETH WADE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
PAULINE EDWARDS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
219-64-7305 | | 17. INFORMANT
ADDRESS
LARRY N. SCRUGGS SAME AS 13 HUSBAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Metastatic Breast Cancer</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>immediate</u>
<u>2 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>July 1, 1984</u> to <u>March 19, 1985</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE | | 22c. DATE SIGNED
3/20/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. FREDERICK SMITH | | 22e. ADDRESS
5401 WESTERN AVENUE, N.W., WASHINGTON, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
3/23/85 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD | | 23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE
MAR 26 1985 <u>[Signature]</u> | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | |

2134

086060

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FRANK W. SEPHRE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-21-85 | | 2b. HOUR
2:40 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 13, 1888 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NURSING HOME, GIVE STREET ADDRESS)
Sylvan Manor Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF LAST YEAR)
Retired | | 12b. KIND OF BUSINESS OR
(TYPE OF WORK FOR MOST OF LAST YEAR)
Pattern maker |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
074-01-7324 | | 17. INFORMANT ADDRESS
Daniel Poole same as 13c | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease with
DUE TO, OR AS A CONSEQUENCE OF
(b) cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 18 | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5/2 |
| MEDICAL CERTIFICATION | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21/85 to 3/21/85, that (I) (we) last saw the deceased live on 3/21/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Barry N. Rosenbady, M.D. | | DEGREE | | 22c. DATE SIGNED
3/21/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY N. ROSENBADY, M.D. | | 22e. ADDRESS
3720 FARRAGUT AVE.
KENSINGTON, MD 20851 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/22/85 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pkce, Rockville, Maryland 20852 | | 25a. DAY RECEIVED BY REGISTRAR
MAR 26 1985 | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

7-11-64

TO: DIRECTOR, FBI
FROM: SAC, LOS ANGELES
SUBJECT: [illegible]
RE: [illegible]
[illegible text follows]

[illegible text]

[illegible text]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DONALD LAWRENCE SETTLE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAR 10 1985 | | | 2b. HOUR
3:28 AM | | | |
| 3. SEX
MALE | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 21 35 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASHINGTON D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
TAKOMA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
WASHINGTON ADVENTIST HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TITLE Abstractor | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | | 13b. COUNTY
MONT. | | 13c. CITY OR TOWN
TAKOMA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
Edgar | | | 15. MOTHER'S MAIDEN NAME
Bebel | | | 13e. STREET ADDRESS / ZIP CODE
327 Bayd Ave Takoma Park | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
217-36-7943 | | 17. INFORMANT
Bebel D. Settle | | ADDRESS
(13e) | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-Pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) **Septic Shock**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Ascending Cholangitis**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

DCholelithiasis (2) Congestive Heart Failure (3) Cardiomegaly (4) Agonism (5) Hypertension

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
3/6/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ascending Cholangitis | | 19c. ATOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF OTHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 20c. HOW INJURY OCCURRED (Enter nature of injury in item 19, Part I or Part 2) | | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21b. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from **19 67** to **3/10 19 85** that (I) (we) lost
saw the deceased alive on **3/9 19 85** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|--|--|--|--|--|
| 22b. SIGNATURE
Alan R. Gair MD | | DEGREE | | 22c. DATE SIGNED
3/10/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ALAN R. Gair MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. ADDRESS
11700 Old Columbia Pike
Silver Spring, Md | |

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial. | | 23b. DATE
March 12, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Bladensburg Rd. P.G. Md. | |
| 24. FUNERAL DIRECTOR
(NAME)
John Katter | | 25a. ADDRESS
254 Carroll St. | | 25b. DATE
MAR 13 1985 | | 25c. REGISTRAR'S SIGNATURE
Gillian Davidson-Rendall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|---|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | MONTHS DAYS HOURS MIN. | |
| VERONICA | | 3-21-85 | | 913/P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| FEMALE | White | MONTH DAY YEAR | 84 | IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Pennsylvania | USA | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Silver Spring, Md | NOLAN CROSS HOSPITAL | | Homemaker | | own home |
| 13a. STATE | | 13b. CITY OR TOWN | 13c. STREET ADDRESS / ZIP CODE | | |
| Maryland | Montgomery | Rockville | 3503 Turkey Branch Pkwy. 20853 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. ADDRESS | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | FIRST MIDDLE LAST | |
| John Budock | | Wanda Mateka | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| N/A | | 202-10-4373 | | Bernadette S. Hurd-dau-(same as 13e) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Budosis</u> | | | | | 3D |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> | | | | | 2D |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Perforated Viscus</u> | | | | | 1D |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>malabsorption</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| NONE | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/21</u> , 19 <u>85</u> , to <u>3/21</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive <u>3/21</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.) | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>E. A. Oristian</u> | | MD | | 3/24/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| E. A. Oristian MD | | 344 University Blvd W Silver Sp | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3-25-1985 | | St. Josephs Cemetery | |
| | | | | 23d. LOCATION | |
| | | | | CITY OR TOWN COUNTY STATE | |
| | | | | Mt. Carmel Northumberland PA | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Hines/Rinaldi Funeral Home | | MAR 26 1985 | | <u>[Signature]</u> | |
| 11800 N.H. Ave., Silver Spring, Md. | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

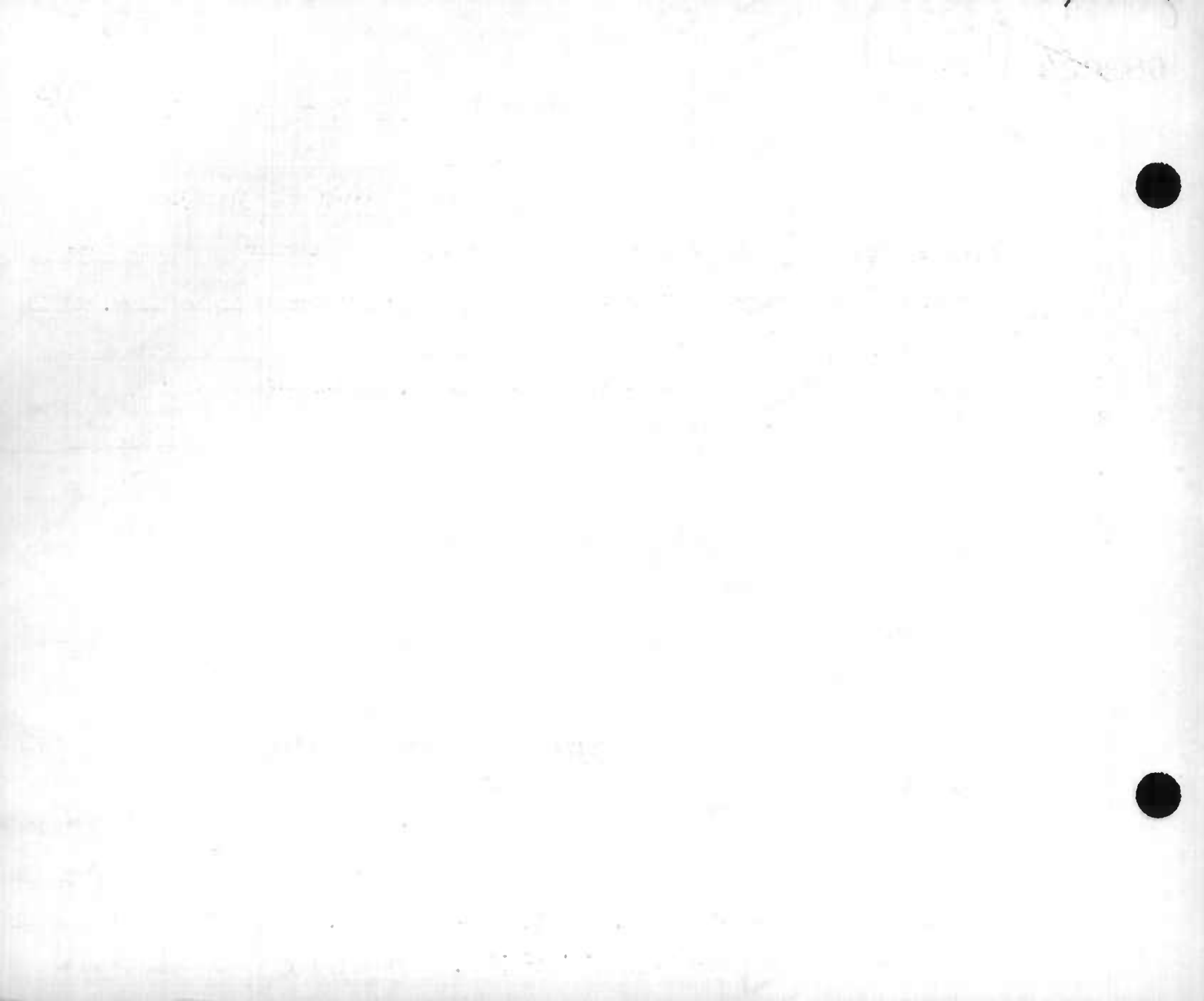
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

John S. Rogers, DME

Notified & approved by funeral director

088023

09035



08812712

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 09036

| | | | | | | | |
|--|--|---|---|---|----------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)
MURIEL MIDDLE JEAN LAST SHEPHERD
Muriel Jean Shepherd | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 21 85 | | 2b. HOUR A
1035 M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
6 4 29 | | 6. AGE (IN YEARS LAST BIRTHDAY)
55 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
KENTUCKY USA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CO-OWNER MANAGER | | 12b. KIND OF BUSINESS OR INDUSTRY
CONSTRUCTION | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | | 13b. COUNTY
MONT | | 13c. CITY OR TOWN
ROCKVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
118 MONTGOMERY ST MT 409 | | 14. FATHER'S NAME FIRST MIDDLE LAST
JESSE E. BURTON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
FANNIE - BARTON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
303324481 | | 17. INFORMANT
C. ALLEN SHEPHERD | | ADDRESS
SAME AS # 13 | | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA LUNGS TO BRAIN BONES.
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA OF LUNGS.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|--|--|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
OLD COAST (P) hemiplegia hypertension. | | | |
|--|--|--|--|

| | | | | | | | |
|------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
|------------------------|--|--|--|--|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | |
|--|--|--|--|--|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
|--|--|--|--|---|--|

| | | | | | |
|---|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 3/18/85 to 3/21/85, that (I) (we) last saw the deceased alive on 3/21/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
|---|--|--|--|--|--|

| | | | | | |
|---------------------------------|--|----------------|--|-----------------------------|--|
| 22b. SIGNATURE
Ruth Cosca MD | | DEGREE
M.D. | | 22c. DATE SIGNED
3/21/85 | |
|---------------------------------|--|----------------|--|-----------------------------|--|

| | | | | | |
|---|--|--|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RUTH COSCA, MD | | 22e. ADDRESS
17524 REDLAND ROAD
DERWOOD MD 20851 | | | |
|---|--|--|--|--|--|

| | | | | | | | |
|---|--|----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
MAR. 23, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Mont. Md. | |
|---|--|----------------------------|--|---|--|---|--|

| | | | | | |
|---|--|---|--|---|--|
| 24. FUNERAL DIRECTOR
FRANCIS H. BARBER LAYTONSVILLE, MD. 20879 | | 25a. DATE REGD. BY REGISTRAR
MAR 26 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Hendall | |
|---|--|---|--|---|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked other than "1" when any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|---|--|-----------------------------------|---|---|
| 1 - STATE REGISTRAR | | REG. NO. | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) Charlotte Sherman | | | | | 2a DATE OF DEATH
MONTH DAY YEAR
March 4, 1985 | | | 2b HOUR P ^M
3:10 | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
1-15-03 | | 6 AGE (IN YEARS LAST BIRTHDAY)
82 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN)
Russia | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10 CITY OR TOWN OF DEATH
Olney | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hosptial | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a STATE
Maryland | | 13b COUNTY
Montgomery | | 13c CITY OR TOWN
Gaithersburg | | 13e STREET ADDRESS / ZIP CODE
9168 Centerway Rd. 20874 | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Irwin Spiegelman | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
N/A | | 17 INFORMANT ADDRESS
Bonnie Klem daughter same address as #13 | | | | | |
| II CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
(b) Cerebrovascular accident
(c) Aspiration pneumonia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: () | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3/4/85
10/18/85 |
| | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> OFFSHORE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(ATHLETIC STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 10/28 19 85 to 3/4 19 85 ; that (i) (we) last saw the deceased alive on 3/4 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (i) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dr. Schoengold | | | | | DEGREE
MD | | 22c. DATE SIGNED
3/4/85 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Schoengold | | | | | 22e. ADDRESS
18111 Pine Ridge Dr. Olney, Md 20832 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
METHOD
Burial | | | 23b. DATE
March 6, 1985 | | | 23c. PLACE OF BURIAL OR CREMATION
Judean Mem. Gns | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Olney, Maryland | |
| 24 FUNERAL DIRECTOR
NAME
Ives-Pearson Funeral Homes | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 08 1985 | | | | |
| 25b. REGISTRAR'S SIGNATURE
John R. ... | | | | | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked, item 48 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

094070

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) Chun Min T. Shih | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3/03/85 | | | 2b. HOUR
MIN.
2154 | | | |
| 3 SEX
Female | | 4 RACE
Chinese Oriental | | 5. DATE OF BIRTH
MONTH DAY YEAR
6 19 11 | | 6 AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
China | | 7b. CITIZEN OF WHAT COUNTRY?
Rep. of China | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
13811 Loree Lane 20853 | | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
SUN TANG | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LIU TANG | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
219-18-1337 | | 17. INFORMANT
ADDRESS
Jemmy Shih. Same as item 13. | | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory arrest secondary to metabolic encephalopathy
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) Pentacost fibrosis and intestinal obstruction
DUE TO, OR AS A CONSEQUENCE OF
(c) Gastric Carcinoma Stage IV
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
One week
three months
Half to One year | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 19 84 to Mar 23 19 85 , that (I) (we) last saw the deceased alive on Mar 23 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Jen-hwei Lee | | | DEGREE
MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Mar 23, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lee, Jen-hwei | | | 22e. ADDRESS
14960 Carry Back Drive Gaithersburg, MD 20878 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/30/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | | | | | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | | | | | | | |

THE LOCAL HEALTH DEPARTMENT EQUITY STATE
Silver Spring Maryland

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09039

1- STATE REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|--|--|---|--|--|--|--------------------------|--|-------|--|------|--|------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | | |
| David | | H. | | Shoe | | | | March 7 | | 19 | | 85 | | 338 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| M | W | Nov. 4 63 | | 21 YRS. | | | | | | March 7 | | 19 | | 85 | | 538 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Georgia | | United States | | | | Montgomery | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Olney | | Montgomery | | 11519 | | Student | | Education | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. CITY OR TOWN | | 13c. STREET ADDRESS | | 20853 | | | | | | | | | |
| Montgomery | | Rockville | | 4719 Powder House Rd | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Thomas D. Shoe | | Melba Howell | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| No | | Not Available | | Father | | Same as item 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1 DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | Gunshot wound of head | | | | | | | | | | | | | |
| | | | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| None | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | 0 37 P.M. | | Shot | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | Home | | Powder House Rd | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from | | Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| John S. Rogers, M.D. | | M.D. | | March 7 1985 | | | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | 1919 Seminary Rd. Silver Spring, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | March 10, 1985 | | Norbeck Memorial Park | | Olney, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| | | | | MAR 13 1985 | | Davidson-Randall | | | | | | | | | | | |

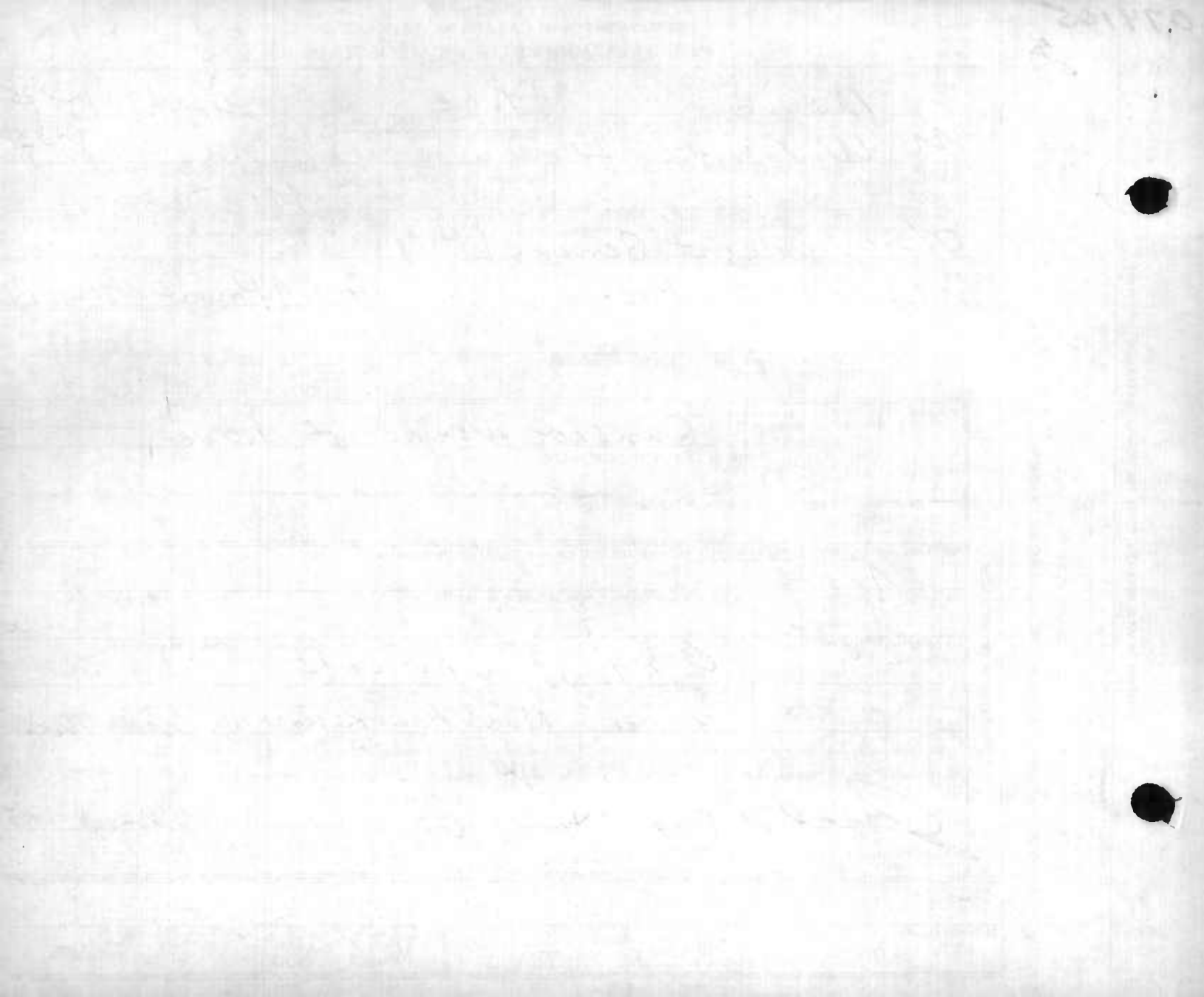
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 9 0

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Harriman N Simmons, Jr. | | | 2a. DATE OF DEATH
MONTH 3 DAY 7 YEAR 85 7:30 P.M. | | |
| 3. SEX
Male | 4. RACE
white | 5. DATE OF BIRTH
MONTH Mar DAY 12 YEAR 1904 | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | | 7. UNDER 1 YEAR
MONTHS 80 DAYS 80 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Brooke Grove Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Dir. Public Safety DOD | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Silver Spring | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST Harriman MIDDLE N. LAST Simmons, Jr. | | 15. MOTHER'S MAIDEN NAME
FIRST Eleanor MIDDLE Nelson LAST Nelson | | 13e. STREET ADDRESS / ZIP CODE
3339 S. Leisure World Blvd. 20906 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1943-1957 056-10-3801 | | 17. INFORMANT
ADDRESS
Mary B. Simmons, Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory Arrest | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease | | | | | Year- |
| DUE TO, OR AS A CONSEQUENCE OF (c) AHD & Senile Cardio myopathy | | | | | Years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 1979 to 17 Feb 19 85 , that (I) first last saw the deceased alive on 17 Feb 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 27b. SIGNATURE
Gustavo S. Belaval | | DEGREE
M.D. | | 27c. DATE SIGNED
7 Mar 85 | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gustavo S Belaval | | 27e. ADDRESS
Leisure World Medical Center
Silver Spring, Md 20905 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Mar. 12, 1985 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN Arlington COUNTY Virginia STATE Virginia |
| 24. FUNERAL DIRECTOR
NAME Francis J. Collins ADDRESS 500 University Blvd. W., Silver Spring, Md. | | 25a. DATE REC'D. BY REGISTRAR MAR 13 1985 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



081049

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|---|---------|--|--|---|--|---|--|--|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| BETTY | | | | | | SMITH | | 3 | | 10 | | 19 | | 85 | | 10 A.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 24 YRS. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| Female | White | Sept. 10, 1905 | | 79 YRS. | | | | | | 3-13 | | 19 | | 85 | | 10 A.M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Russia | | U.S.A. | | WIDOWED | | DIVORCED | | Montgomery County, MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Rockville | | 12000 Old Georgetown Rd., #C204 | | Steno./Bookkeeper | | | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Montgomery | | Rockville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 12000 Old Georgetown Rd., #C204 | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Rubin | | Smith | | Sadie | | Gorelick | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | | | | | |
| NO | | 121-03-0283 | | Charles E. Smith | | 1802 Kalorama Sq.; Wash., D.C. 20008 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | Cardiac arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (b) Coronary arteriosclerosis | | | | | | | | | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| | | | | | | (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | | | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 | | | | | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | | | STREET | | CITY OR TOWN | | COUNTY | | STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | | | | | | | | | | | |
| John Lauber | | Deputy | | 3-13-85 | | | | | | | | | | | | | |
| EXAMINER'S NAME | | ADDRESS | | | | | | | | | | | | | | | |
| John Lauber | | 8218 Wisconsin Ave | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | 3/15/85 | | Adas Israel Cemetery | | Washington, D.C. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | NAME | | DANZANSKY-GOLDBERG MEMORIAL CHPLS. | | MAR 18 1985 | | | | | | | | | | | |
| | | 1170 Rockville Pike; Rockville, Md. 20852 | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

021013

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED

RECEIVED

099153

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 4 2

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|--|------------------------------|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Jennie Smith</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>03 30 85</i> | | 2b. HOUR
<i>1:10 A.M.</i> | | | | | | |
| 3 SEX
<i>Female</i> | | 4 RACE
<i>CAUCASIAN</i> | | 5 DATE OF BIRTH
MONTH DAY YEAR
<i>09 21 93</i> | | 6 AGE (IN YEARS LAST BIRTHDAY)
YRS.
<i>91</i> | | 7 IF UNDER 1 YEAR
MONTHS DAYS
<i>0 0</i> | | 8 IF UNDER 24 HRS.
HOURS MIN.
<i>0 0</i> | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Poland</i> | | 7b CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
<i>MONTGOMERY</i> MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
<i>CHEVY CHASE</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Bethesda Retirement Nursing Center</i> | | | | 12a USUAL OCCUPATION
(TYPE OF WORK OR BUSINESS)
<i>HOMEMAKER</i> | | 12b KIND OF BUSINESS OR INDUSTRY
<i>HOME</i> | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
<i>MD. MONTG. CHEVY CHASE</i> | | | | | | 13b INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c STREET ADDRESS / ZIP CODE
<i>8700 JONES MILL RD. 20815</i> | | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
<i>PINCUS PIANKO</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>SARAH KAPITOVSKY</i> | | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO NA</i> | | | |
| 16b SOCIAL SECURITY NO.
<i>349-28-6104</i> | | | | 17 INFORMANT
<i>8917 CHERBOURG DR. POTOMAC, MD.</i> | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 year</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>5 year</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>Hypertension</i> | | | | | | | | | | | |
| 19a DATE OF OPERATION
<i>3-4</i> | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <i>3-4</i> , 19 <i>79</i> , to <i>3-30</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>3-13</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (that) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Morton Kavalier</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>3/30/85</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>DR. MORTON KAVALIER</i> | | | | 22e ADDRESS
<i>1145 19th st. N.W. WASH D.C.</i> | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
<i>BURIAL</i> | | 23b. DATE
<i>4-2-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>WESTLAWN CEM.</i> | | 23d. LOCATION
CITY COUNTY STATE
<i>COOK CO. NORWOOD PK.</i> | | | | | |
| 24 FUNERAL DIRECTOR'S NAME
<i>DANZANSKY-GOLDBERG MEM CHP.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 03 1985</i> | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>ILL.</i> | | | | | | 25c. REGISTRAR'S SIGNATURE
<i>ILL.</i> | | | | | |

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20.2 COTTON L

CHILD

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 4 3

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Lillian E. Smith | | | 2a. DATE OF DEATH
MONTH 03 DAY 01 YEAR 1985 | | | 2b. HOUR
5:55A | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH 11 DAY 22 YEAR 23 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Suburban Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. STATE
MD. | | | 13b. CITY OR TOWN
MONTGOMERY | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
1606 LANSDOWNE WAY 20910 | | |
| 14. FATHER'S NAME
FIRST MIKE MIDDLE MORRIS LAST MILLER | | | 15. MOTHER'S MAIDEN NAME
FIRST ROSE MIDDLE LAST UNKNOWN | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
295-14-8742 | | 17. INFORMANT
MILTON SMITH | | ADDRESS
SAME AS ITEM #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EXTENSIVE Abdominal CARCINOMATOSIS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 month | |
| DUE TO, OR AS A CONSEQUENCE OF
(b) Colon Cancer | | | | | | | | 7 month | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12 Aug 1970 to 1 Mar 1985 , that (I) (we) lost saw the deceased alive on 1 Mar 1985 , and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eugene P. Libbre MD | | | | | | DEGREE MD | | 22c. DATE SIGNED
1 Mar 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
EUGENE P. LIBBRE MD. | | | | | | 22e. ADDRESS
10400 CONNECTICUT AVE
KENSINGTON, MD. 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | 23b. DATE
3-2-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE P.G.C. Md. | | |
| 24. FUNERAL DIRECTOR
NAME
W. W. CHAMBERS CO. INC. | | | | | ADDRESS
SILVER SPRING, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 4 1985 | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
Jane Davidson-Randall | | | | |

72
70
65
60
1

2
9
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 4 4

1- FOR
STATE
REGISTRAR

REG. NO.

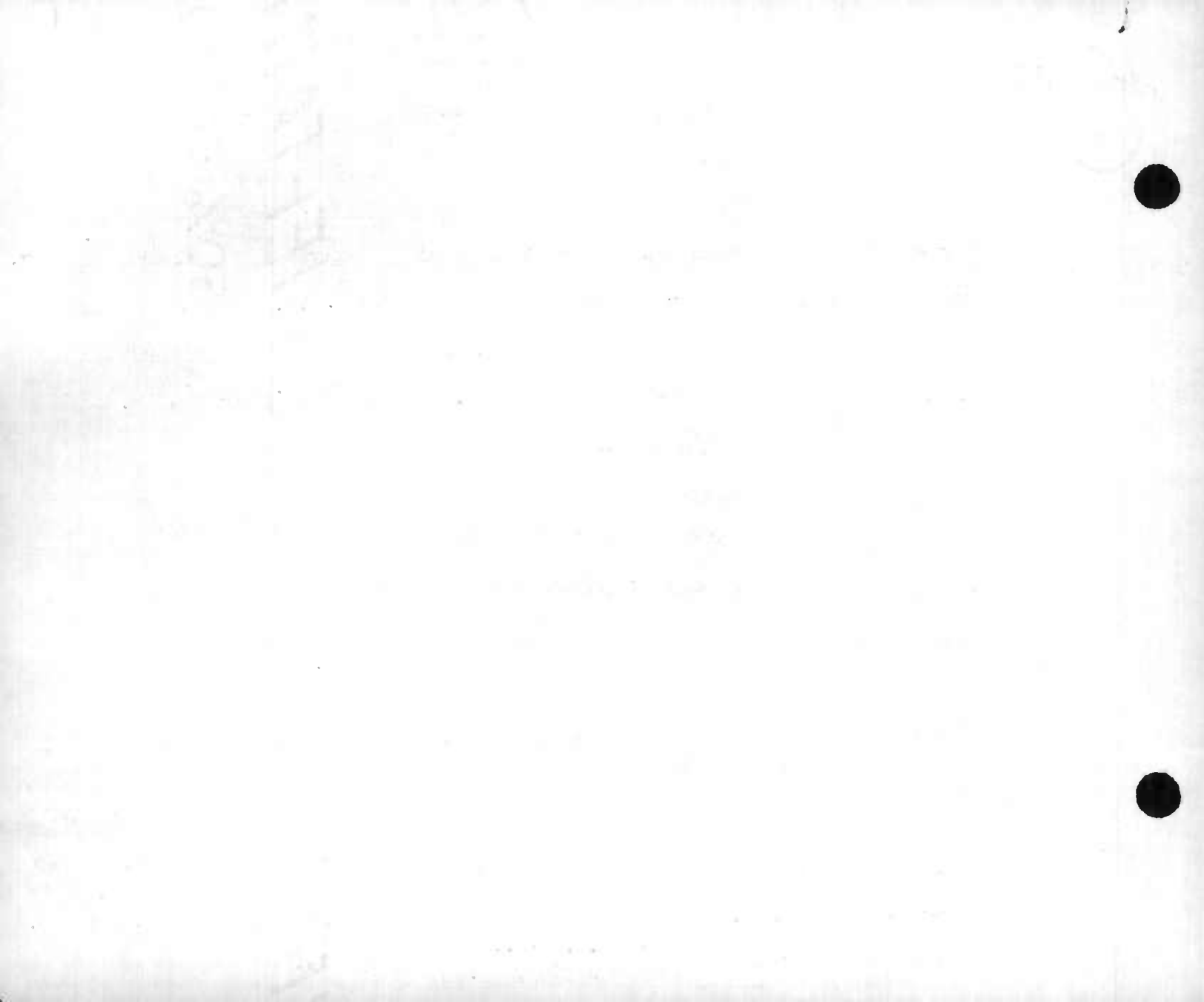
| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>MARY FRANCES SMOOT</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR <u>March 30 1985</u> | | 2b. HOUR
<u>11:14 P.M.</u> |
| 3. SEX
<u>Female</u> | 4. RACE
<u>White</u> | 5. DATE OF BIRTH
MONTH DAY YEAR <u>July 12 1894</u> | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>90</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery</u> MD. | | |
| 10. CITY OR TOWN OF DEATH
<u>Takoma Park</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Washington Adventist Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired</u> | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Income Tax Div.</u> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Montgomery</u> 13c. CITY OR TOWN <u>Silver Spring</u> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST <u>Calvin Cochran</u> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST <u>Rebecca Cochran</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) <u>N/A</u> | | 16b. SOCIAL SECURITY NO.
<u>579-22-0113</u> | | 17. INFORMANT
<u>Jerry T. Smoot-son-</u> | |
| | | | | ADDRESS
<u>Rt. 1 Box 99E Strasburg, Va. 22657</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSECTERIC CARDIOVASCULAR DISEASES</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:
<u>GENERALIZED ARTERIOSECTERIC DISEASES</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 21</u> 19 <u>85</u> to <u>March 30</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>March 30</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Bernard A. Fitzgerald</u> | | DEGREE
<u>M.D.</u> | | 22c. DATE SIGNED
<u>3-31-85</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>BERNARD A. FITZGERALD</u> | | 22e. ADDRESS
<u>217 UNIVERSITY BLVD E, SILVER SPRING, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>Apr. 3, 1985</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven</u> | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Silver Spring Montgomery Md.</u> | | 23e. DATE REC'D. BY REGISTRAR
<u>APR 2 1985</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Hines/Rinaldi Funeral Home</u> | | 11800 N.H. Ave.,
SILVER SPRING, MD. | | 25b. REGISTRAR'S SIGNATURE
<u>Wardson Handall</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. For a copy of the form, see page 1 of the instructions. The low requires that the death certificate be executed within 24 hours after death. For a copy of the form, see page 1 of the instructions.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or checked, a medical examiner must be notified of the death.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A 15 ME (5))
30M 7/73

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. |
|---|---------|---|--------|---|---|---|---|---|-------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | <input checked="" type="checkbox"/> MONTH | DAY | YEAR | 2b. HOUR |
| Rodman W. Snowden | | | | | 3-12-1985 | | | | | 11:50 P. M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | Black | Nov 13, 1920 | | 64 YRS. | MONTHS | DAYS | 3-12-1985 | | 11:50 P. M. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Dist. Columbia | | U.S.A. | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Montgomery MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Sandy Spring | | 19215 Chandlee Mill Rd, | | | Engineer | | Montg Co Sch | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Md | | Montgomery | | Sandy Spring | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 19215 Chandlee Mill Rd, 20860 | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | |
| Nicholas B. Snowden | | | | Eleanor Hopkins | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No | | | | 214-18-9059 | | Mrs Carolyn N. Snowden Same As 13#E | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a). <u>Acute leukemia.</u> | | | | | | | | | | 10 mos. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: | | | | | | | | | | |
| (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| None | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| None | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| | | | | P.M. 19 | | None | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | |
| | | | | | | STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | |
| | | | | M.D. Deputy | | | | 3/13/85 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | |
| John S. Rogers, M.D. | | | | 1919 Seminary Road Silver Spring, Montgomery, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | | |
| Burial | | 3-16-85 | | Ash Memorial Cem. | | | Sandy Spring, Montg. Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | |
| George R. Snowden | | | | 246 N. Washington St. Rockville, Md. 20850 | | | | MAR 15 1985 | | |

10 men.

Route 1000.

None

None

None

X

X

3000

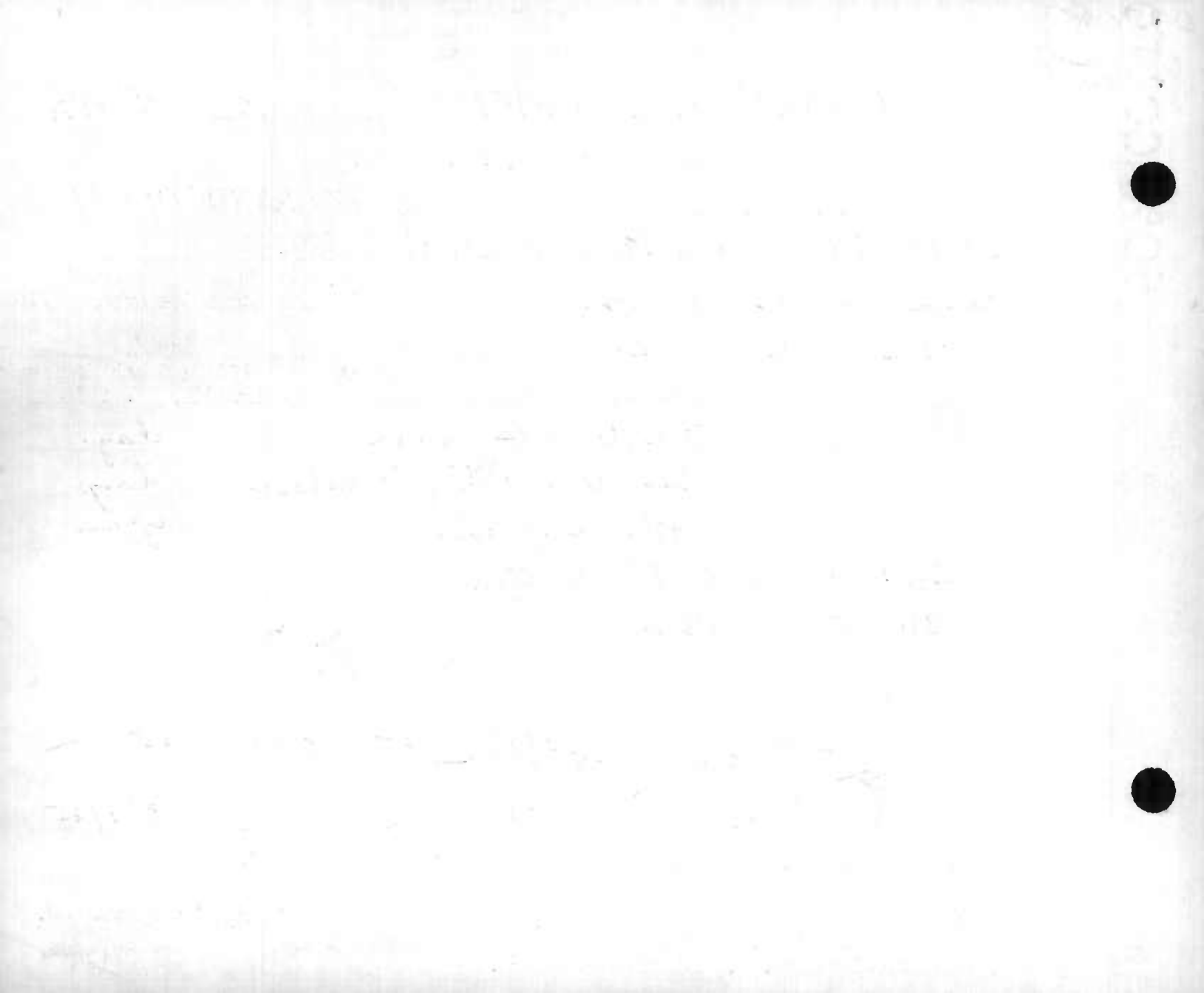
2000

1000

500

John E. Smith, N.Y.

1000



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8509047

093067

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
FANNIE SOLOMON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 25, 1985 | | 2b. HOUR
3:50a.m. |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 20, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79
YRS MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Wheaton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Randolph Hills Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner (Retired) | | 12b. KIND OF BUSINESS OR INDUSTRY
Knitting Store |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Jacob Seidel | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Simpson | | 13e. STREET ADDRESS / ZIP CODE
1902 Sunrise Drive (20854) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
131-09-0261 | | 17. INFORMANT
ADDRESS
George M. Solomon; 1902 Sunrise Drive; Rockville, Maryland 20854 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)
rhinotracheal cellulitis; Varicella zoster | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from Feb 26, 1985 to March 25, 1985 that (1) (we) saw the deceased alive on March 25, 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Martin C. Shargel | | DEGREE
M.D. | | 22c. DATE SIGNED
3/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MARTIN C. SHARGEL | | 22e. ADDRESS
3720 FARRAGUT AVE
KENSINGTON MD - 20895 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | 23b. DATE
3/26/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Nebo Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Miami, Florida | | 24. FUNERAL DIRECTOR
NAME
DANZANSKY-GOLDBERG MEMORIAL CHAPELS | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
MAR 27 1985 John Davidson-Rodgers | | | |

033063



POSSIBLE ACTION FOR

WINTER/SPRING

Q

WINTER/SPRING

12-22-2008 11:58 AM

081143

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|---|---|---|--|---|--|----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FRANCISCO SOMOZA | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 15, 1985 | | | 2b. HOUR
5:00 PM | |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 14, 1913 | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NICARAGUA | 7b. CITIZEN OF WHAT COUNTRY?
NICARAGUA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY Co. MD | | | | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
6809 PERSIMMON TREE RD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RET.-FARMER | | 12b. KIND OF BUSINESS OR INDUSTRY
FARMING | | |
| 13a. STATE
MD. | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
BETHESDA | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
6809 PERSIMMON TREE RD. 20817 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ERNESTO SOMOZA | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NATALIA BALLADARES | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT ADDRESS
CARLOS G. MUNIZ (SAME AS #13) | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

UREMIA

DUE TO, OR AS A CONSEQUENCE OF

(b)

GLOMERULONEPHRITIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

CORONARY HYPERTENSION

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

CORONARY ARTERY DISEASE

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
— P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/14 19 85 to 3/16 19 85 that (I) (we) last saw the deceased alive on 3/10 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
KNOSSUL MD | | DEGREE | | 22c. DATE SIGNED
15 March 85 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. KALDAN NOSSULI M.D. | | 22e. ADDRESS
11606 BUNNEL COURT BETHESDA MD. | | | | | |

| | | | |
|---|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
3-16-1985 | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREM. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE, PGC. MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
W. W. CHAMBERS CO. INC. SILVER SPRING, MD. | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1985 | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a valuable contribution to the study of the country's social development.

088126

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) STEVEN COREY SOULEN
<i>Steven Soulen</i> | | | 2a. DATE OF DEATH
MONTH 3 DAY 16 YEAR 85 | | 2b. HOUR
9:57 P.M. |
| 3. SEX
MALE
<i>M</i> | 4. RACE
WHITE
<i>W</i> | 5. DATE OF BIRTH
MONTH 3 DAY 9 YEAR 48 | | 6. AGE (IN YEARS LAST BIRTHDAY)
37 YRS. | IF UNDER 1 YEAR
MONTHS 37 DAYS 16 |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MINNESOTA | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LAND SURVEYER | | 12b. KIND OF BUSINESS OR INDUSTRY
SURVEY CO. |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SILVER SPRING | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST RUSSELL MIDDLE ARTHUR LAST SOULEN | | | 15. MOTHER'S MAIDEN NAME
FIRST ELIZABETH MIDDLE RUTH LAST NELSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-50-6891 | | 17. INFORMANT
ADDRESS
LINDA SOULEN, WIFE, SAME AS ITEM #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) acute Cardiac myopathy
DUE TO, OR AS A CONSEQUENCE OF
(c) Right lower lobe Pneumonia | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
sudden
5 days
2 weeks |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Hypertension | | | | | |
| 19a. DATE OF OPERATION
Feb 25 1985 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Acute Cardiac myopathy | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 25 1985 to Mar 16 1985 , that (I/we) last saw the deceased alive on Mar 16 1985 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Michael R. Dobridge MD</i> | | DEGREE
MD | | 22c. DATE SIGNED
Mar 16 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael R. Dobridge MD | | 22e. ADDRESS
13975 Conn. Ave Silver Spring Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
cremation | | 23b. DATE
3/17/85 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | |
| 23d. LOCATION
CITY OR TOWN
ALEXANDRIA, VIRGINIA | | 23e. STATE
VIRGINIA | | 23f. DATE REC'D. BY REGISTRAR
MAR 26 1985 | |
| 24. FUNERAL DIRECTOR
NAME
RICHARD RAPP, INC. | | ADDRESS
1904 T ST., N.W., WASH., D.C. 20009 | | 25b. REGISTRAR'S SIGNATURE
<i>James Davidson-Randall</i> | |

MEDICAL CERTIFICATION

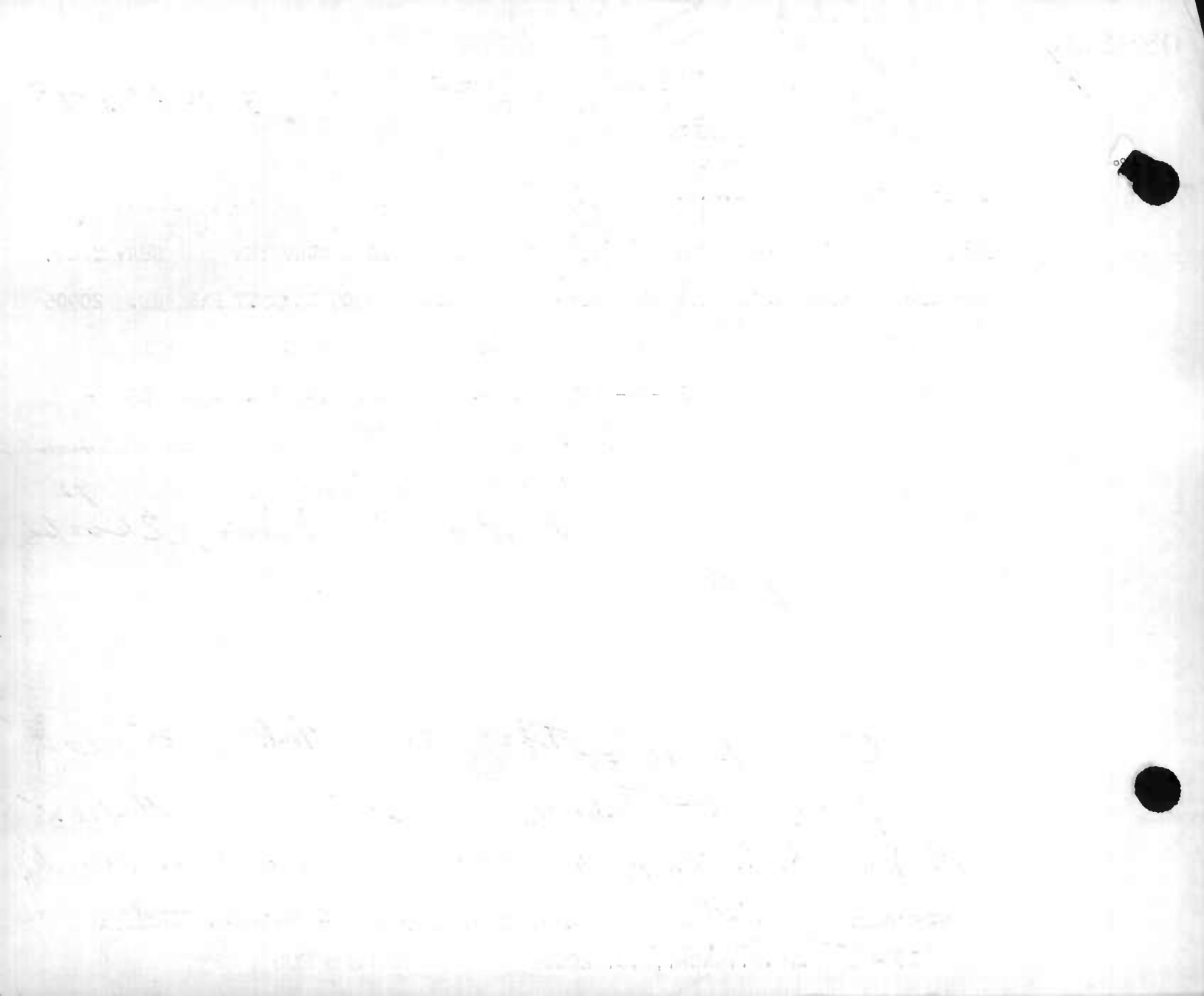
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or initialed shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

094088

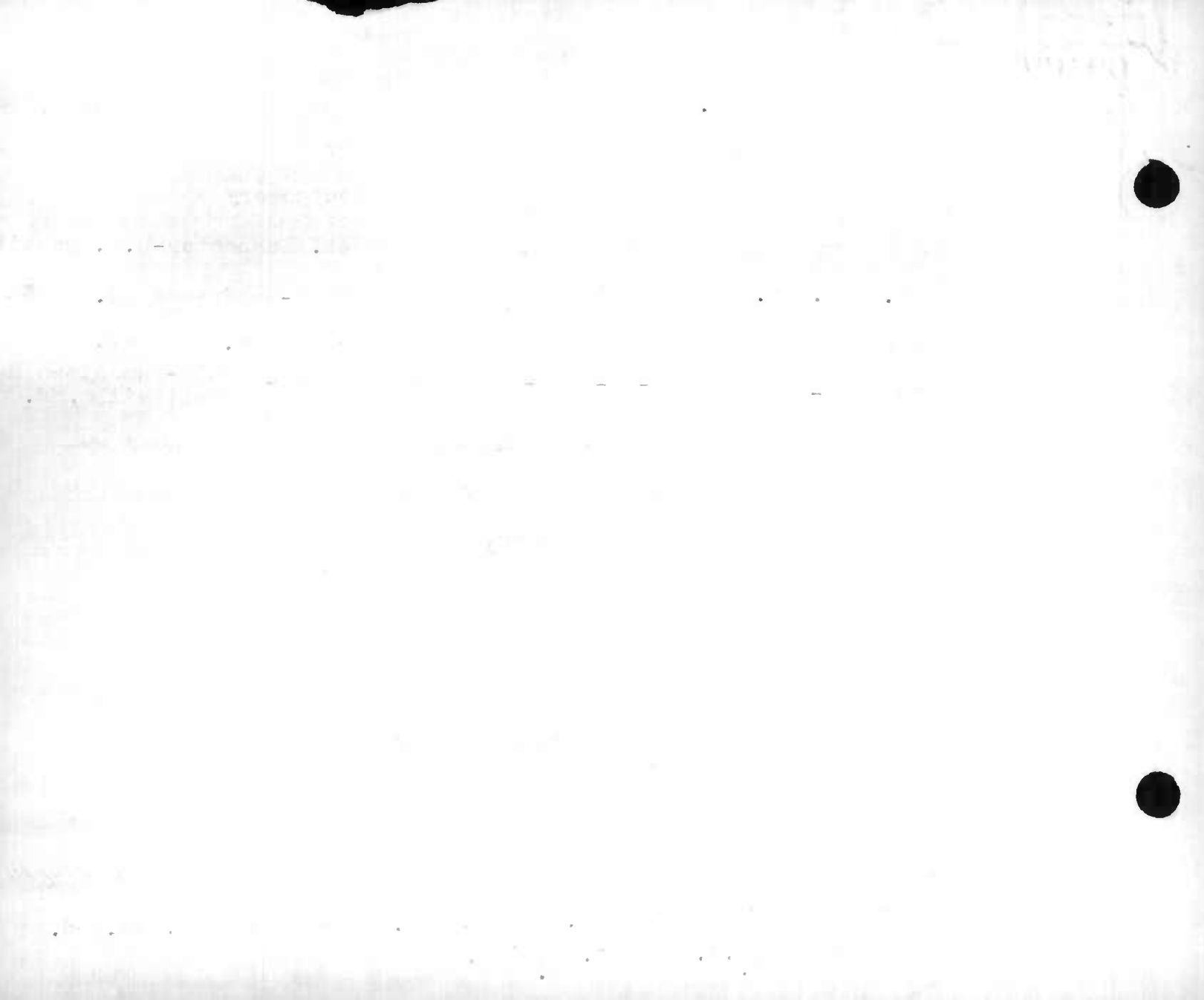
| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT) CLARENCE B. SPARKS | | | 2a. DATE OF DEATH MONTH DAY YEAR
MAR 21 1985 | | | 2b. HOUR
6:15 PM | |
| 3 SEX
M | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 - 13 - 00 | | 6 AGE (IN YEARS LAST BIRTHDAY)
85 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENN. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10 CITY OR TOWN OF DEATH
WHEATON MD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MANOR CARE WHEATON | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Inspector | |
| 12b. KIND OF BUSINESS OR INDUSTRY
D.C. Transit | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Avondale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leroy Sparks | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Luzetta V. Beal | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-10-7417 | | 17. INFORMANT ADDRESS
Gertrude Smay - 5635-Jamestown Rd. Hyattsville, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma Lung
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-2 days
2 months
Several months | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 19 65 to MAR 21 19 85 , that (I) (we) last saw the deceased alive on MAR 14 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert B. Irey | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
3-21-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ROBERT B. IREY | | 22e. ADDRESS
11161 New Hampshire Ave, Silver Spring MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/25/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo. Md. | |
| 24. FUNERAL DIRECTOR NAME
Nalley's F.H. Inc. | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 28 1985 | | 25b. REGISTRAR'S SIGNATURE
John F. ... | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



086144

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
James Speros | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAR 14 '85 | | 2b. HOUR
3 (P) M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 8 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Greece | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Potomac | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
11700 River Road | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant |
| 13a. STATE
Md. | | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Potomac | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Leonidas Speros | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Angeliki (Unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-03-4832 | | 17. INFORMANT
Vasilikie Speros, Wife. Same as item 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest - Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Pericarditis
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Myocardial Infarction | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 3 hrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
ALZHEIMERS DISEASE OF AGED | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from Jan 64 , to March 14 1985 , that (1) (we) last saw the deceased alive on March 9 1985 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Richard J. Meyer | | | | 22c. DATE SIGNED
Mar. 15 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Richard J. Meyer, M.D. | | | | 22e. ADDRESS
4731 Mass. Ave., N.W. Wash., D.C. 20016 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/18/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rodville Maryland | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Joseph Gawler's Sons Inc.
5130 Wisc. Ave., N.W. Wash., D.C. | | | |
| 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
MAR 21 1985 | | | |

MEDICAL CERTIFICATION

99

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

(MARIE BERNADETTE)

MAE

B.

STEPHENS

2a. DATE OF DEATH

3 8 85

2b. HOUR

3 P M

3. SEX

FEMALE

4. RACE

CAUCASIAN

5. DATE OF BIRTH

APRIL 3, 1888

6. AGE (IN YEARS LAST BIRTHDAY)

96

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN)

New Jersey

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10. CITY OR TOWN OF DEATH

KENSINGTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

KENSINGTON GARDENS NURSING HOME

12a. USUAL OCCUPATION

EXEC. SECRETARY

12b. KIND OF BUSINESS OR

INDUSTRY

G.A.O.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

MONTGOMERY

13c. CITY OR TOWN

SILVER SPRING

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

1316 FENWICK LA

20910

14. FATHER'S NAME

FIRST

JOHN

MIDDLE

S.

LAST

JAMISON

15. MOTHER'S MAIDEN NAME

FIRST

CATHRENA

MIDDLE

J.

LAST

EUSTICE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

YES, NO OR UNKNOWN

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

579-60-5349

17. INFORMANT

ADDRESS

KENSINGTON, MD

JOHN E. STEPHENS 3120 HOMEWOOD PKWY.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Congestive heart failure

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

2 days

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b) probable myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

(c) advanced age

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

invasive breast carcinoma

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING

☐

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 19 82 to March 8, 19 85, that (I) (we) lost

saw the deceased alive on March 8, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

Barbara Blaylock

DEGREE

M.D.

ATTENDING

MEDICAL

STAFF

22c. DATE SIGNED

3/9/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Barbara Blaylock, M.D.

22e. ADDRESS

611 Executive Boulevard, Rockville, Md. 20852

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

BURIAL

23b. DATE

MAR. 12, 1985

23c. NAME OF CEMETERY OR CREMATORY

ARLINGTON NAT'L CEM

23d. LOCATION

CITY OR TOWN

ARLINGTON

COUNTY

STATE

VA.

24. FUNERAL DIRECTOR

NAME

FRANCIS J. COLLINS

ADDRESS

500 UNIV. BLVD

25a. DATE REC'D. BY REGISTRAR

MAR 13 1985

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

WEST, SILVER SPRING, MD 20901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|-----------------------------|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LOUIS D. Sterling | | | 2a. DATE OF DEATH
MONTH 3 DAY 25 YEAR 85 | | 2b. HOUR
12 30 AM |
| 3. SEX
m | 4. RACE
w | 5. DATE OF BIRTH
MONTH 2 DAY 7 YEAR 17 | 6. AGE (IN YEARS LAST BIRTHDAY)
68 | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | | | 10. CITY OR TOWN OF DEATH
Silver Spring | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sport Chev. | | 12b. KIND OF BUSINESS OR INDUSTRY
Service |
| 13a. STATE
Md. | | 13b. COUNTY
Mont. | 13c. CITY OR TOWN
Kensington | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
3033 McComas Avenue 20895 |
| 14. FATHER'S NAME
FIRST William MIDDLE Sterling LAST Sterling | | | 15. MOTHER'S MAIDEN NAME
FIRST Celia MIDDLE Sterling LAST Sterling | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577 10 4417 | | 17. INFORMANT
ADDRESS
Hazel Sterling (Wife) Same as 13E | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Cardio-Respiratory Collapse
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Septicemia, staph pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hours
days
± 1 week | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Diabetes mellitus; Liver disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from 19 68 to march 25 19 85 , that (I) (we) lost
saw the deceased alive on march 24 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) did not view the body after death. | | | | | |
| 22b. SIGNATURE
Harold W. Draper M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
3/28/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD W. DRAPER M.D. | | 22e. ADDRESS
9801 GEORGIA AVE, S. LIVER SPRING | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3/28/85 | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville Mont. Md | |
| 24. FUNERAL DIRECTOR
NAME
Hines/Rinaldi | | ADDRESS
11800 New Hamp Ave. S.S. Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1985 | |
| | | 25b. REGISTRAR'S SIGNATURE
Jana Davidson-Randall | | | |

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SKITTED

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | |
|--|------------------|---|--|---|---------------|---|--------------------------------------|--|------------|---|----------|---|---------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Elias | | MIDDLE
(NMN) | LAST
Stetz | | 2a. DATE KNOWN OF DEATH
ESTIMATED | | MONTH
3 | | DAY
3 | YEAR
1985 | 2b. HOUR
3:01 PM |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
8 4 01 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
83 YRS. | | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
3 3 85 | | 19 | | 2d. HOUR
3:01 PM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Austria | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Rockville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
400 Carl Street 20851 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Alexander Stetz | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathryn Voloshczuk | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | (IF YES, GIVE WAR OR DATES)
GIVE SERVICE AND UNIT | | 16b. SOCIAL SECURITY NO.
051-16-2639 | | 17. INFORMANT
ADDRESS
Loretta Towalt same as 13e | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <u>Coronary arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John Tauber | | | | TITLE (SPECIFY)
M.D. Deputy | | | | MEDICAL EXAMINER
Bethesda Md. | | | | DATE SIGNED
3-3-85 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
John Tauber | | | | ADDRESS
8218 Wisconsin Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
3/8/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Lawn Memorial Park | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pine Lawn, New York | | | |
| 24. FUNERAL DIRECTOR
NAME
Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852 | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 6 1985 | | 25b. REGISTRAR'S SIGNATURE
Davidson Handell | | | | | |

Handwritten text, possibly a list or index, written vertically in the center of the page. The text is faint and difficult to decipher, but appears to consist of several lines of characters.



088131

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9055

| | | | | | | |
|---|--|--|--|---|----------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EMILY E. STEVENS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 19 1985 | | 2b. HOUR
11:05 P _M | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 20 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DISTRICT OF COLUMBIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY County, MD. | | 10. CITY OR TOWN OF DEATH
BETHESDA | | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Never Employed | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
MONTGOMERY | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ERNEST EVANS STEVENS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LOUISE WILTON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
530-14-0066 | | 17. INFORMANT
ADDRESS
ERNEST E. STEVENS, 4970 BATTERY LANE, APT #409, BETHESDA, MD 20814 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) SEPTIC SHOCK DUE TO PURULENT PYELONEPHRITIS
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 6 19 85 to MARCH 19 19 85 that (I) (we) last saw the deceased alive on MARCH 19 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
R. L. NEMEC, LT, MC, USNR | | | | DEGREE
MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
20 MAR 85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. L. NEMEC, LT, MC, USNR | | | | 22e. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
March 23, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Robert A. Pumphrey, Funeral Homes, P.A., Bethesda, Maryland 20814 | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 26 1985 | | 25b. REGISTRAR'S SIGNATURE
James Harrison |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



082173

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Cleared by Crow-DiMaio

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR Nora L. StevensonSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
NORA L. STEVENSON | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 8, 1985 | | 2b. HOUR
1232 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
8 28 1899 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County MD. | | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired- Balto. | 12b. KIND OF BUSINESS OR INDUSTRY
Gas & Electric | |
| 13a. STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Pikesville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
Md. 21208
12 Brightside Ave. Pikesville, | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John T. Stevenson | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Belle Sullivan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
212-05-7160A | | 17. INFORMANT ADDRESS
Rev. Lively Gruber Same as 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Thoracic Aortic Aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Aortic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>Years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | 21g. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3/8/85</u> 19 <u>75</u> to <u>date</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>3/8/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Thos B. Ward</u> | | DEGREE
<u>MD</u> | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/8/85 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Thos B. Ward</u> | | 22e. ADDRESS
<u>6. WARD, 6116 ROBIN WOOD, BETHESDA 20817</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
3/12/85 | 23c. NAME OF CEMETERY OR CREMATORY
Druid Ridge Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pikesville Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Leroy M. & Russell C. Witzke Funeral Home | | | 25a. DATE REC'D. BY REGISTRAR
MAR 11 1985 | | |

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098185

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHCleared 4/9/85
3:00 AM

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
JAMES AMOS STONEBERGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3 25 85 | | 2b. HOUR
MIN.
12³⁰ A M | | |
| 3. SEX
Male. | | 4. RACE
White. | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 18 1941 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
83 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Takoma Park. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)
Washington Adventist Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOSPITAL EMPLOYEE | | 12b. KIND OF BUSINESS OR INDUSTRY
LAUNDRY. | |
| 13a. STATE
Maryland. | | | | 13b. COUNTY
Takoma Park. | | 13c. CITY OR TOWN
Takoma Park. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STONEBERGER | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
NOT AVAILABLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
W-W-II 216-46-0603 | | 17. INFORMANT
ADDRESS
MARY A. STONEBERGER - 904 DAVIS AVE | |

18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Septic shock

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

1 day

DUE TO, OR AS A CONSEQUENCE OF

(b)

Severe Dehydration

1 week

DUE TO, OR AS A CONSEQUENCE OF

CVA

2 wks

(c)

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

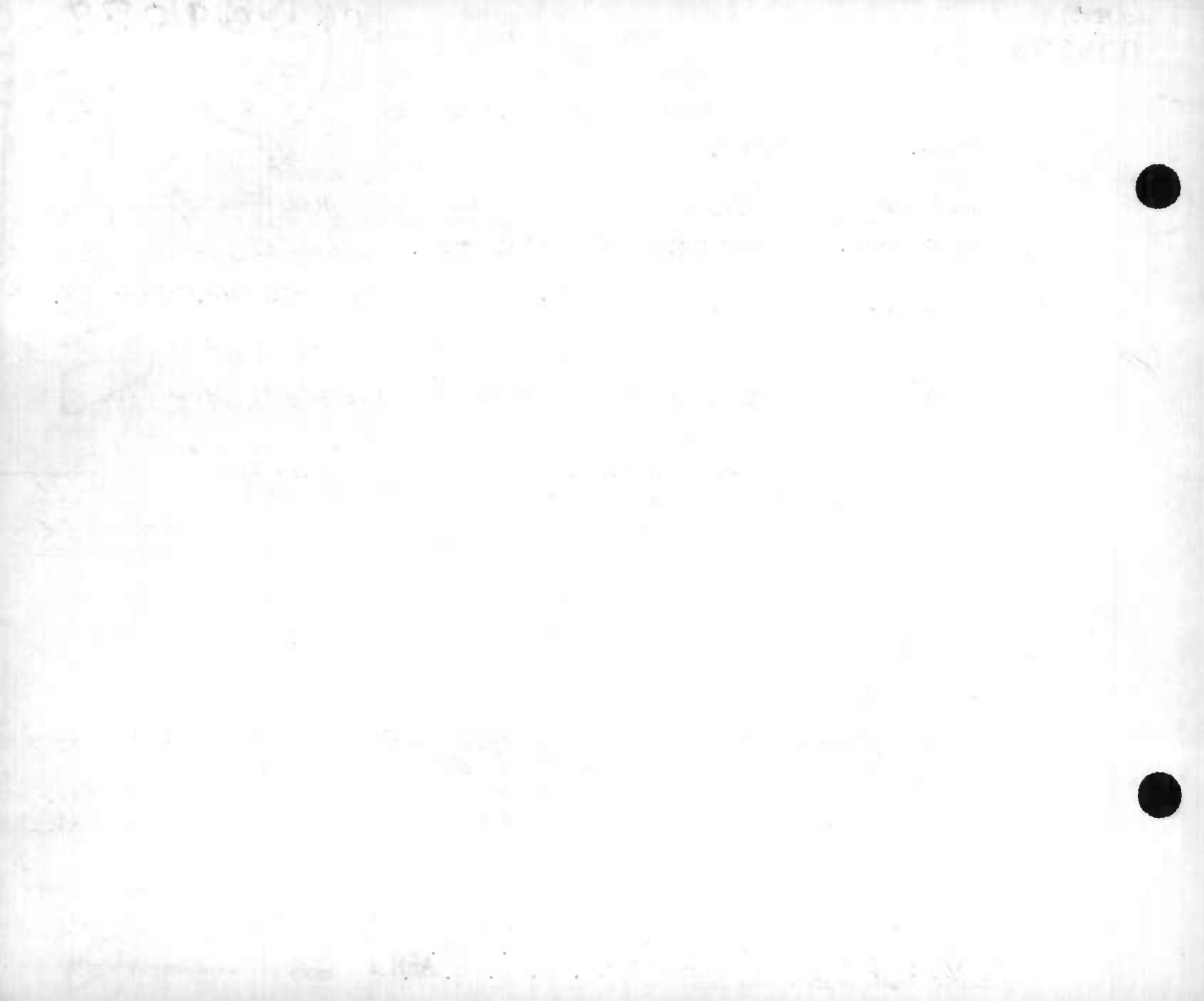
| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/24/85</u> to <u>3/25/85</u> , that (I) (we) last saw the deceased alive on <u>3/25/85</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
David Cromwell | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
3/25/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID CROMWELL, MD. | | 22e. ADDRESS | | | | | |

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
MARCH 26, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD MD | |
| 24. FUNERAL DIRECTOR
Robert J. Hall | | Takoma Funeral Home, Inc.
254 Carroll St. N. W. D. | | 25a. DATE REC'D. BY REGISTRAR
APR 1 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18, 19, 20 is any injury, or other traumatic event, the medical examiner must be notified at once.)



087034

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Fred H. STROUPHAUER | | | 2a. DATE OF DEATH
MONTH 3 DAY 16 YEAR 85 | | | 2b. HOUR
10 33 PM | |
| 1. SEX
Male | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH 2 DAY 27 YEAR 22 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
62 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10. CITY OR TOWN OF DEATH
Silver Spring, md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MANAGER | |
| 13a. STATE
MD | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Wheaton | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE STROUPHAUER LAST STROUPHAUER | | 15. MOTHER'S MAIDEN NAME
FIRST VERNA MIDDLE REHER LAST REHER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | |
| 16b. SOCIAL SECURITY NO.
203-07-7859 | | 17. INFORMANT
MARY T. STROUPHAUER | | ADDRESS
SAME AS 13 (WIFE) | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Thrombosis, mid body collateral
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis of aorta
DUE TO, OR AS A CONSEQUENCE OF
(c) Capnotomy for carcinoma of pancreas | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
19 days | |
|--|--|---|--|

| | | | |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Capnotomy for carcinoma of pancreas | | | |
| 19a. DATE OF OPERATION
2/27/85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
As above | |
| 20a. ALLOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |

| | | | | | |
|--|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **2/26**, 19 **85**, to **3/16**, 19 **85**, that (I) (we) lost
saw the deceased alive on **2/16**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (that) (did not) (saw) the body (after) death.

| | | | |
|---|--|---|--|
| 22b. SIGNATURE
W T Marcus MD | | 22c. DATE SIGNED
3/17/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
W T MARCUS MD | | 22e. ADDRESS
10301 GA AVE SILVER SPRING, MD | |

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) CREMATION | | 23b. DATE
3/18/85 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN ALEXANDRIA COUNTY VIRGINIA STATE | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 400 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | 25a. DATE REC'D. BY REGISTRAR
MAR 22 1985 | | 25b. REGISTRAR'S SIGNATURE
Wardson-Randall | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0870293

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
Virginia P. Sullinger | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 18, 1985 | | 2b. HOUR
A M
10:05 |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
FEB. 27, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MISSOURI | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hsptial | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
TEACHER | 12b. KIND OF BUSINESS OR INDUSTRY
SCHOOL | |
| 13a. STATE
Md. | | | 13b. COUNTY
MONTGOMERY | 13c. CITY OR TOWN
SANDY SPRING | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET ADDRESS / ZIP CODE
17330 QUAKER LA. 20860 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES O. PAULSELL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CLARA UNDERWOOD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
267-24-1652 | | 17. INFORMANT
ADDRESS
MRS. PATRICIA STEADMAN 74 PORTLAND RD.
SUMMIT, N.J. 07901 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cachectic pulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Complete Heart Block / Pulmonary Edema</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Aspiration pneumonia</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3/18/85</i>
<i>3/4/85</i>
<i>3/4/85</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Parkinson Disease, severe. Pulmonary fibrosis</i> | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/13/85</i> 19 <i>85</i> to <i>3/18</i> 19 <i>85</i> , that (I) (we) lost
saw the deceased alive on <i>3/13/85</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. <i>(I) (we) did (and not) view the body after death.</i> | | | | | |
| 22b. SIGNATURE
<i>Arthur Schoengold MD</i> | | DEGREE | | 22c. DATE SIGNED
<i>3/18/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Schoengold | | 22e. ADDRESS
18111 Prince Philip Dr. Olney, Md. 20832 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
3-20-1985 | | 23c. NAME OF CEMETERY OR CREMATORY
CHAMBERS CREMATORY | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
RIVERDALE, P.G.C., Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
W. W. CHAMBERS CO. INC. | | ADDRESS
SILVER SPRING, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAR 22 1985 | |
| 25b. REGISTRAR'S SIGNATURE | | | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09060

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | | | | | | |
|---|--|---------|--|--|--|-------------------|--|--|--|---|--|---|--|-----------------------------------|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE KNOWN OF DEATH | | | | 2b. DATE PRONOUNCED DEAD | | | | 2c. DATE OF DEATH | | | | 2d. HOUR | | | |
| JOHN D. SULLIVAN | | | | 3-1-85 | | | | 3-1-85 | | | | 9:50A | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 24 HRS. | | 8. MARRIED | | 9. NEVER MARRIED | | 10. DIVORCED | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Male | | Cauc. | | Mar. 28, 1956 | | 28 YRS. | | | | <input checked="" type="checkbox"/> WIDOWED | | <input type="checkbox"/> NEVER MARRIED | | <input type="checkbox"/> DIVORCED | | Montgomery County MD. | | | |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 13. CITIZEN OF WHAT COUNTRY? | | | | 14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 16. KIND OF BUSINESS OR INDUSTRY | | | |
| Washington, DC | | | | United States | | | | Holy Cross Hospital | | | | Salesman | | | | Automobile | | | |
| 17. CITY OR TOWN OF DEATH | | | | 18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 20. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Silver Spring | | | | Holy Cross Hospital | | | | Salesman | | | | Automobile | | | | | | | |
| 21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 22. CITY OR TOWN | | | | 23. INSIDE CITY LIMITS? | | | | 24. STREET ADDRESS | | | | | | | |
| Maryland | | | | Montgomery | | | | Rockville | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 1010 Welsh Drive/20850 | | | |
| 25. FATHER'S NAME | | | | 26. MOTHER'S MAIDEN NAME | | | | 27. INFORMANT | | | | 28. ADDRESS | | | | | | | |
| John Roy Thompson | | | | Martha Turner | | | | Donna J. Sullivan, same as #13 | | | | | | | | | | | |
| 29. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 30. SOCIAL SECURITY NO. | | | | 31. INFORMANT | | | | 32. ADDRESS | | | | | | | |
| No | | | | 214-70-3636 | | | | Donna J. Sullivan, same as #13 | | | | | | | | | | | |
| 33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | 34. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I DEATH WAS CAUSED BY: Mechanical asphyxia | | | | | | | | | | | | | | | | | | | |
| 8150 IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 35. DATE OF OPERATION | | | | 36. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 37. AUTOPSY? | | | | | | | |
| | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 38. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 39. TIME OF INJURY | | | | 40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN CITY, PART 1 OR PART 2) | | | | | | | | | | | |
| | | | | 8:30AM 3-1-85 | | | | driver of a flat bed trailer carrying a car struck a rail causing trailer to overturn along with car | | | | | | | | | | | |
| 41. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 42. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 43. LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | | | | | | | | |
| | | | | hwy. | | | | Inner loop Rt. 495 Silver Spring, Md. | | | | | | | | | | | |
| 44. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | |
| 45. ACTUAL SIGNATURE | | | | 46. TITLE (SPECIFY) | | | | 47. DATE SIGNED | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | Assistant | | | | 3-2-85 | | | | | | | | | | | |
| 48. EXAMINER'S NAME (TYPE OR PRINT) | | | | 49. ADDRESS | | | | 50. LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | | | | | | | | |
| Margarita A. Korell, M.D. | | | | 111 Penn Street | | | | Alexandria, Virginia | | | | | | | | | | | |
| 51. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 52. DATE | | | | 53. NAME OF CEMETERY OR CREMATORY | | | | 54. LOCATION (CITY OR TOWN, COUNTY, STATE) | | | | | | | |
| Cremation | | | | 3, 1985 | | | | Metropolitan Crematory | | | | Alexandria, Virginia | | | | | | | |
| 55. FUNERAL DIRECTOR | | | | 56. DATE REC'D BY REGISTRAR | | | | 57. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850 | | | | MAR 5 1985 | | | | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17
(VR A15 ME (5))



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WINDY & CLOUDY

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>William L. Surber</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>3 5 '85</i> | | | 2b. HOUR
<i>21¹⁰</i> M | |
| 3. SEX
<i>M.</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>5 15 '13</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>71</i> YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>VA</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>US</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery County</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Takoma Park</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Washington Adventist Hospital</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Manager</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Service Sta.</i> | |
| 13a. STATE
<i>Maryland</i> | | 13b. CITY OR TOWN
<i>Pr. Georges Temple Hills</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
<i>2905 Brinkley Rd. #102 20748</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Claiborne Lee Surber</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Dora Anderson</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>W.W.II</i> | | 17. INFORMANT ADDRESS
<i>Dora Jane Surber as in item #13e</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Lung Cancer</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>2 years</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<i>Arteriosclerotic Cardiovascular Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT HOME | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from <i>15 JAN 85</i> to <i>5 MAR 85</i> , that (2) (we) lost
saw the deceased alive on <i>5 MAR 85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE
<i>Thomas A. Bensinger</i> | | DEGREE
<i>MD</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/6/85</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>THOMAS A. BENINGER MD</i> | | 22e. ADDRESS
<i>7525 Greenway Center Drive Greenbelt MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>3-9-85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY
<i>Suitland Pr. Georges Md.</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>G.P. Kalas</i> | | ADDRESS
<i>6160 Oxon Hill Rd. Oxon Hill, Md.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 8 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Rendell</i> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

item #11m #602
4/8/85 jpsSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Arlene Rose Taylor | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 22, 1985 | | | 2b. HOUR
2.45 am | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 24, 1938 | | 6. AGE (IN YEARS LAST BIRTHDAY)
46 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Beauty Salon | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland Montgomery Germantown | | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
18630 Mustard Seed Court 20874 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William McCabe | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
Thelma Kennel | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | 16b. SOCIAL SECURITY NO.
214 36 4752 | |
| 17. INFORMANT
Husband
Robert J. Taylor | | | ADDRESS
Same as item 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>chronic liver disease</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>several mo.</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>hypertension</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> , 19 <i>85</i> , to <i>3/24</i> , 19 <i>85</i> , that (II) (we) lost <i>show the deceased alive on above</i> , and that (III) (my) (our) opinion death occurred on the date and hour and from the causes stated. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Edw. H. Rutter</i> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>3/24</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Sanford Richman, M.D. | | | 22e. ADDRESS
Gaithersburg, Maryland
19221 Montgomery Village Avenue | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
March 26, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 28 1985 | | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | | |

030920



081139

Item 2a Per. Fall From F.H. STATE OF MARYLAND
 FOR 3/28/85JAB
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1 - STATE REGISTRAR
 CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) HELEN C. TAYLOR | | | 2a. DATE OF DEATH MONTH DAY YEAR
March 13, 1985 | | | 2b. HOUR
10:50 P_M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 2, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Shady Grove Adventist Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. STATE
Virginia | | 13b. COUNTY
Norfolk | | 13c. CITY OR TOWN
Norfolk | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert Frank Creecy | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sarah Elizabeth Baker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
227 32 4019 | | 17. INFORMANT
NAME ADDRESS
Daughter 12924 Circle Way
Jean Twist Rockville, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Mass plug aspiration.
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebral Infarct - Absent gag & swallowing | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
Cerebral Infarct - Hemiplegia - Atrial Fibrillation | | | | | | | |
| 19a. DATE OF OPERATION
3-13-85 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2:32 3 1985 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
9715 Medical Center Dr. Norfolk, Virginia | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-3-85 , 19 85 , to 3-13-85 , 19 85 , that (I) (we) last saw the deceased alive on 3-13-85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
John E. Kelly | | | | DEGREE
ATTENDING PHYSICIAN | | 22c. DATE SIGNED
3-18-85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN E. KELLY | | | | 22e. ADDRESS
9715 Medical Center Dr. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
March 16, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Norfolk, Virginia | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND | | | | 25a. DATE REC'D. BY REGISTRAR
MAR 20 1985 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Rendell | | | |



100% COTTON FIBER

DOWD

WELLS

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|--|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Robert Edward Taylor | | | 2a DATE OF DEATH
MONTH DAY YEAR
3/17/85 | | 2b HOUR
8:30pm |
| 3 SEX
Male | 4 RACE
Black | 5 DATE OF BIRTH
MONTH DAY YEAR
Nov. 10, 1910 | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | 7 UNDER 1 YEAR
MONTHS DAYS
2 MONTHS 15 DAYS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD | | |
| 10 CITY OR TOWN OF DEATH
Olney | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Montgomery General Hospital | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Laborer | 12b KIND OF BUSINESS OR INDUSTRY
Mark & Planning | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Md. | | | 13b COUNTY
Howard | 13c CITY OR TOWN
Columbia | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Edward R. Taylor | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lottie E. Cook | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b SOCIAL SECURITY NO.
216-12-4827 | | 17 INFORMANT
ADDRESS
Lula Mae Taylor (Friend) same as #13 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic Adenocarcinoma of Stomach 8 months
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e PLACE OF INJURY
(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (if this hospital) attended the deceased from 3/14 , 19 85 , to 3/17 , 19 85 that (1) <input checked="" type="checkbox"/> last saw the deceased alive on 3/15 , 19 85 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> did not view the body after death. | | | | | |
| 22b SIGNATURE
Jules R. Lodish MD | | DEGREE | | 22c. DATE SIGNED
3/18/85 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
JULES R. LODISH | | 22e ADDRESS
2901 Olney - Sandy Spring Road | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
3-22-85 | 23c. NAME OF CEMETERY OR CREMATORY
Mutual Mem. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sandy Spring, Montg. Md. | |
| 24 FUNERAL DIRECTOR
NAME
George R. Snowden Rockville, Md. 20850 | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE
Jules R. Lodish | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

1080131

8:30P

2/17/52

Robert M. Taylor

Montgomery

Montgomery State Hospital

Albany

[Faint, illegible handwritten text, possibly a letter or report.]

093030

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

09065

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<u>Gladys I. Thiess</u> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<u>3-28-85</u> | | 2b. HOUR
<u>4:50 PM</u> |
| 3. SEX
<u>FEMALE</u> | 4. RACE
<u>WHITE</u> | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>4-12-1899</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>85</u> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
<u>85</u> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>N. CAROLINA</u> | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Montgomery Co.</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Silver Spring</u> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Holy Cross Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Retired-Helper</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>School</u> |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>MD</u> | | | 13b. COUNTY
<u>Montgomery</u> | 13c. CITY OR TOWN
<u>Silver Spring</u> | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>ADOLPH BURTON</u> | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
<u>BURLEIGH DYLER</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO
<u>220-28-7445</u> | | 17. INFORMANT
ADDRESS
<u>FRANK J. THIESS (SAME AS ITEM #13)</u> | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute cerebral infarction</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> |
| DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Cerebral arteriosclerosis</u> | | <u>Several years</u> |
| DUE TO, OR AS A CONSEQUENCE OF:
(c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Pneumonia, acute renal failure

MEDICAL CERTIFICATION

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE FARM ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 1950</u> to <u>March 28 1985</u> that (I/we) last saw the deceased alive on <u>March 28 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
<u>Sydney Laronthal, M.D.</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
<u>3/25/85</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Sydney Laronthal, M.D.</u> | | 22e. ADDRESS
<u>1400 Lafayette Dr. Silver Spring, Md.</u> | |

| | | | |
|--|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>CREMATION</u> | 23b. DATE
<u>3-29-1985</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>CHAMBERS CREM.</u> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>RIVERDALE PGC. MD.</u> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>W. W. CHAMBERS CO INC SILVER SPRING MD.</u> | | 25a. DATE REC'D. BY REGISTRAR
<u>APR 3 1985</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>W. W. Chambers</u> | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. These permits require carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked by item 18 above any injury, or other traumatic event, the medical examiner must be notified of this.

4

078079

#13b,c, FilmG602 4/2/85 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|-----------------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) SUSIE A. REAMS TINSLEY | | | 2a. DATE OF DEATH
MONTH 3 DAY 12 YEAR 85 2b. HOUR 7:40 P.M. | | |
| 3. SEX
FEMALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH 3 DAY 20 YEAR 03 | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. MONTHS — DAYS — HOURS — MIN. — | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) NC | 7b. CITIZEN OF WHAT COUNTRY?
US | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Sil. Sp. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Holy Cross Hosp | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR MAIN SOURCE OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE
(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE MD COUNTY Mont. CITY OR TOWN Sil. Sp. | 13b. CITY OR TOWN INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS
4603 Amherst Rd 20740 | | | |
| 4. FATHER'S NAME
FIRST JOSEPH MIDDLE — LAST REAMS | | 15. MOTHER'S MAIDEN NAME
FIRST EURAH MIDDLE — LAST GREEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
219-74-4248 | | 17. INFORMANT
DOROTHY T. BROCKETT DAUGHTER SAME AS 13 | |
| 11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) — | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: — | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/12 19 85 , to 3/12 19 85 , that (I) (we) last saw the deceased alive on 3/12 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | |
| 21g. SIGNATURE
[Signature] | | DEGREE | | 22c. DATE SIGNED
3/12/85 | |
| 21h. PHYSICIAN'S NAME (TYPE OR PRINT)
MOORE H. ELK | | 22b. ADDRESS
9801 Goya Ave, Silver Spring MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) BURIAL | | 23b. DATE
MAR 16 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW MAPLEWOOD CEMETERY DURHAM | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS 500 UNIVERSITY BLVD., W SILVER SPRING, MD. | | 25a. DATE RECD. BY REGISTRAR
MAR 18 1985 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3-13-82

THURSDAY

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THURSDAY

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N.C.

Half Cross Hop

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was harvested

1/2

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THURSDAY

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N.C.

112

21.2



082176

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) EVA EUGENIA TROTT | | | 2a. DATE OF DEATH MONTH DAY YEAR
3 - 10 - 85 | | 2b. HOUR 12 A M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
July 12 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 72 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Gaithersburg | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Wilson Health Care Gaith. Md | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Montgomery | | |
| 13c. CITY OR TOWN
Gaithersburg | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John W. Sherbert | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Ann Crosby | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
220-44-9065 | | 17. INFORMANT
ADDRESS
Asbury Methodist Home-301 Russell Ave., Gaithersburg, Md. 20760 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral atrophy
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cerebral disease
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years
years
" |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: emaciation | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/16/85 to 3/10/85 , that (I) (we) last saw the deceased alive on 3/16/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Thos G. Ward | | 22c. ADDRESS
4116 Robinwood Bethesda, Md 20817 | | 22d. DATE SIGNED
3/10/85 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
3/13/85 | | 23c. NAME OF CEMETERY OR CREMATORY
Friendship Meth. Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Friendship (Anne Arundel) Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Richard A. Coleman Funeral Home-Md. 20772 | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 12 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21b is marked, the medical examiner must be notified at once.

BP

STATE OF NEW YORK
IN SENATE



RECEIVED
JAN 10 1896

OFFICE OF THE
COMMISSIONER OF
THE LAND OFFICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's office must be notified immediately.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|--|--------------------------------------|--|---|--|---|--|
| <div>FOR STATE REGISTRAR</div> <div>REG. NO.</div> | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | MONTH | | DAY YEAR | | 2b. HOUR | |
| To Van Truong | | | | March 24 1985 | | 1:40 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | |
| Male | | Vietnamese | | 12 / 10 / 12 | | 72 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Vietnam | | Vietnam | | | | Montgomery MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY | | | | | | | |
| Silver Spring | | Holy Cross Hospital | | House of Representatives Retired Deputy/Vietnamese | | | | | | | |
| 13a. STATE | | | | | | | | | | 13b. CITY OR TOWN | |
| Maryland | | | | | | | | | | Montgomery | |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13d. STREET ADDRESS / ZIP CODE | |
| | | | | | | | | | | 12000 Garner Street 20902 | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Nhiu Ngoc Truong | | | | Hue Thi Ho | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | ADDRESS | |
| No | | | | 586-50-3685 | | Rosine T. Vu | | | | 9111 Cherbourg Dr. Potomac, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE - ASYSTOLE | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE - BRAIN DEATH | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL VASCULAR ACCIDENT | | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/24/85 to 3/24/85, that (I) (we) lost the deceased alive on 3/24/85, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| Robert J. Williams | | | | MD | | | | 3/24/85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| Robert J. Williams | | | | 2101 MEDICAL PK DR SILVER SPRING | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | |
| Cremation | | | | 3/27/85 | | Cedar Hill Crematory | | Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | | | |
| Pyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852 | | | | | | MAR 29 1985 | | | | | |

250321

935 - NOTICE 978

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked as item 18 then any injury or other traumatic event, the medical examiner must be notified directly.)

081023

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|--|--|--|--|---|------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
<i>IDA Tucker</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>3 / 12 / 85</i> | | 2b. HOUR
<i>12 34 P M</i> | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR
<i>7 17 1890</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
<i>94</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Russia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Montgomery</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Bethesda</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Suburban Hosp.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Own Home</i> | |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>Montgomery</i> | | 13c. CITY OR TOWN
<i>Rockville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
<i>unknown</i> | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
<i>Rachel Horowitz</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>077-28-5013</i> | |
| 17. INFORMANT ADDRESS
<i>Sally Rosenfeld 3709 S. Geo. Mason Dr. F.C. VA</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 Day</i>
<i>4 d</i> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from <i>3/12</i> 19 <i>85</i> , to <i>3/12</i> 19 <i>85</i> , that (b) (we) last saw the deceased alive on <i>3/12</i> 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Peter B. Sherer</i> | | DEGREE <i>MD</i>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/13/85</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Peter B. Sherer</i> | | 22e. ADDRESS
<i>3947 Ferrara Dr. Wheaton, Md. 20906</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>03/14/85</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>King David Mem. Park</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE
<i>Falls Church VA</i> | |
| 24. FUNERAL DIRECTOR NAME
<i>Ives-Pearson Funeral Homes, Falls Church, VA</i> | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
<i>MAR 18 1985</i> | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | |

TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing military operations or personnel matters.]

[Illegible text continues across multiple lines.]

099173

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 7 0

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
DIONNE DALTON TUPMAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 28 1985 | | 2b. HOUR
1:45 P_M |
| 3 SEX
FEMALE | 4 RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 20 1929 | | 6 AGE (IN YEARS LAST BIRTHDAY)
55 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MISSOURI | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY MD. | |
| 10 CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NAVAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
VIRGINIA | | | 13b. COUNTY
ALEXANDRIA | 13c. CITY OR TOWN
ALEXANDRIA | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
JOHN PERRY DALTON | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
INEZ ISABELLE MARTS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | 17 INFORMANT
ADDRESS
EDGAR M. TUPMAN, 109 PRINCESS STREET, | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC LUNG CANCER
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 18 19 85 , to MARCH 28 19 85 , that (I) (we) last saw the deceased alive on MARCH 28 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
J. B. HERMILLER, LT, MC, USNR | | | | 22c. DATE SIGNED
29 MAR 85 | |
| 22d. ADDRESS
NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
4/1/85 | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ARLINGTON VIRGINIA | | |
| 24 FUNERAL DIRECTOR
NAME ADDRESS
DEMAINE FUNERAL HOME ALEXANDRIA, VIRGINIA | | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1985 | 25b. REGISTRAR'S SIGNATURE
<i>Lelia Davidson-Randall</i> | |

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED 12-03-00

01000

MAINTENANCE



11/1

11/1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

082177

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Anthony Nicholas Turiano | | | 2a. DATE OF DEATH
MONTH DAY YEAR
March 04 1985 | | 2b. HOUR
2:30 PM |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov 10 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
3 22 |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
New York | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | | |
| 10. CITY OR TOWN OF DEATH
Bethesda | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Naval Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.A.F. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Florida 13b. COUNTY Dade 13c. CITY OR TOWN Miami | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
9735 NW 52nd St. 99999 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Vincenzo Turiano | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Antonetta Coira | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1940- 1966 | 17. INFORMANT
ADDRESS 709 Clear Springs Rd. Great Falls, VA
Patricia L. Turiano | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Adeno Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (we) (this hospital) attended the deceased from March 1 19 85 to March 4 19 85 that (we) (we) last saw the deceased alive on March 4 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
E. S. Killeavy | | DEGREE
MD | | 22c. DATE SIGNED
04 Mar 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E. S. Killeavy | | 22e. ADDRESS
Naval Hospital, Naval Medical Command
National Capital Region, Bethesda, MD 20814 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
7 Mar 85 | 23c. NAME OF CEMETERY OR CREMATORY
Our Lady of Mercy | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Miami, FL | | |
| 24. FUNERAL DIRECTOR
NAME
Capitol Funeral Service, Falls Church, VA | | 25a. DATE REC'D. BY REGISTRAR
MAR 8 1985 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | |

3

DEBIT NOT TO CREDIT

WILLIAM W. WILSON



100074

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 9 0 7 2

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) ERVIN S. UNGER | | | 2a. DATE OF DEATH MONTH DAY YEAR
MARCH 29, 1985 | | 2b. HOUR
2:31 AM |
| 3 SEX
MALE | 4 RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
NOVEMBER 17, 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
HEBREW HOME OF GREATER WASHINGTON | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
SELF EMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MARYLAND MONTGOMERY ROCKVILLE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
BERTRAM UNGER | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CAROLINE GRUEN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
579-58-5940 | | 17. INFORMANT
JOAN C. NORRIS, 910 CARLYLE WAY EAST, MOBILE, ALABAMA | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF (b) Ecchymotic Head Antr. Bone.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/28/85 , 19 85 , to 3/29/85 , 19 85 , that (I) (we) lost saw the deceased alive on 3-28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert Kramer M.D. | | DEGREE
M.D. | | 22c. DATE SIGNED
3/29/85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. ROBERT KRAMER, M. D. | | 22e. ADDRESS
10313 GEORGIA AVENUE, SUITE 209 SILVER SPRING, MARYLAND | | | |
| 23a. BURIAL CREMATION, REMOVAL
BURIAL | | 23b. DATE
4/1/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
NATIONAL MEMORIAL PARK | |
| 23d. LOCATION
OR TOWN
FALLS CHURCH, VIRGINIA | | | | | |
| 24. FUNERAL DIRECTOR
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME | | 25a. DATE REC'D. BY REGISTRAR
APR 03 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |
| 23e. ADDRESS
232 CARROLL STREET, N. W., WASHINGTON, D. C. | | | | | |

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GERTRUDE FISCHER UNGER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
3-4-85 | | | 2b. HOUR
11:20 | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAR. 22, 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
93 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
NEW YORK | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY CO. MD. | | | |
| 10. CITY OR TOWN OF DEATH
ROCKVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NATIONAL LUTHERAN HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
DRESS MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
CLOTHING | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
NICHOLAS -- FISCHER | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGUERITE -- UNGEMEYER | | | 13e. STREET ADDRESS / ZIP CODE
3838 - ROLAND AVENUE 21211 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
219-30-5799 | | 17. INFORMANT ADDRESS
REV. DR. RICHARD REICHARD - NLH-ROCKVILLE, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
6 days | |
| DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a
Parkinson's Disease | | | | | | | | | |
| 19a. DATE OF OPERATION
--- | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 13, 1973 to March 4, 1985 , that (I) (we) last saw the deceased alive on March 4, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Harold F. McCann | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
3-4-85 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HAROLD F. MCCANN | | | 22e. ADDRESS
3355-16th St. N.W. WASH. D.C. 20010 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
MAR. 7, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDON PARK CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
HYSONG CO., INC. - 1300-N STREET, NW WASH., DC | | | | | | | | | |
| 25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE
MAR 18 1985 <i>John Davidson-Randall</i> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

1-683032

RECEIVED
FEBRUARY 1968

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK

SUBJECT: JAMES EARL RAY
RE: NEW YORK TELETYPE TO BUREAU, 1/24/68

RE: BUREAU TELETYPE TO NEW YORK, 1/24/68

RE: BUREAU TELETYPE TO NEW YORK, 1/24/68

RE: BUREAU TELETYPE TO NEW YORK, 1/24/68

RE: BUREAU TELETYPE TO NEW YORK, 1/24/68

RE: BUREAU TELETYPE TO NEW YORK, 1/24/68

RE: BUREAU TELETYPE TO NEW YORK, 1/24/68

082178

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 09074

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
GEORGE CONSTANTINOS VACHAMIDES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MARCH 5, 1985 | | 2b. HOUR
1:50P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 8, 1975 | | 6. AGE (IN YEARS LAST BIRTHDAY)
9 YRS | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
GREECE | 7b. CITIZEN OF WHAT COUNTRY?
GREECE | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
MONTGOMERY COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
BETHESDA | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NIH, THE CLINICAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
GREECE | | | 13b. CITY OR TOWN
ATHENS | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Constantinos Vachamides | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Demitra makei | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
no | | 16b. SOCIAL SECURITY NO.
n/a | | 17. INFORMANT
ADDRESS
MRS. DEMITRA VACHAMIDES (MOTHER) SAME | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

FAILURE TO WEAN FROM CARDIOPULMONARY BYPASS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

PULMONIC BRANCH STENNOSIS

DUE TO, OR AS A CONSEQUENCE OF

TETRALOGY OF FALLOT

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

TORN AORTIC LEAFLET

19a. DATE OF OPERATION

MARCH 5, 1985

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK
NOT WHILE ☐ AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that ☒ (this hospital) attended the deceased from **FEBRUARY 10, 1985** to **MARCH 5, 1985**, that ☒ (we) lost saw the deceased alive on **MARCH 5, 1985**, and that in **XX** (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.

22b. SIGNATURE

ALLEN MILEWICZ

DEGREE

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

3/6/85

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS
NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 2020523a. BURIAL, CREMATION, REMOVAL
(SPECIFY)**Removal**

23b. DATE

3-9-85

23c. NAME OF CEMETERY OR CREMATORY

K.D. Mystras + Sons23d. LOCATION
CITY OR TOWN COUNTY STATE**Athens, Greece**24. FUNERAL DIRECTOR
NAME**Marshall's Funeral Home
4217 N.W. 11th St. N.W. Wash. D.C. 20011**

25a. DATE REC'D. BY REGISTRAR

MAR 12 1985

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall



BP

DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| I. DECEASED NAME FIRST MIDDLE LAST
Marion R. Von Doenhoff | | | | March 8 1985 9:30A_M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Nov. 17 1909 | | 6. AGE (IN YEARS (LAST BIRTHDAY)) MONTHS DAYS HOURS MIN.
75 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Hampshire | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery MD. | |
| 10. CITY OR TOWN OF DEATH
Bethesda | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
5225 Pooks Hill Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Schools | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Bethesda | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Ira Herbert Abbott | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Catherine Costello | | 13e. STREET ADDRESS / ZIP CODE
5225 Pooks Hill Road 20873 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
231-38-5299 | | 17. INFORMANT ADDRESS
Richard A Von Doenhoff, 26 Oak Shade Rod Gaithersburg, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma Breast
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 years |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 14 19 83 to Mar. 8 19 85 that (I) (we) last saw the deceased alive on Feb. 25 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Charles P. Duvall</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
March 8, 1985 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles P. Duvall | | | | 22e. ADDRESS
3301 New Mexico Ave. N. W. Washington, D. C. 20016 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
3/12/1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Memorial Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Rockville, Md. | |
| 24. FUNERAL DIRECTOR NAME
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash. D.C. | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAR 13 1985 | | | |

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092032

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar within 24 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ARMENIA Frances WADE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
MAR 23 '85 | | 2b. HOUR
8 PM |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
April 13, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Montgomery County, MD. | |
| 10. CITY OR TOWN OF DEATH
Rockville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Collingswood Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | 13c. CITY OR TOWN
Rockville | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Thomas Windle | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rose Bowers | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578 01 3978 | | 17. INFORMANT
Son 2224 Rosedell Place
Donald L. Wade Friendly, Maryland 20744 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GLIOBLASTOMA OF BRAIN
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 MO |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 28 JAN 19 85 to 23 MAR 19 85 , that (I) (we) last saw the deceased alive on 18 MAR 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE OF PHYSICIAN
Walter E. Goode | | | | 22c. DATE SIGNED
24 Mar 85 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
WALTER E. GOODE MD | | | | 22e. ADDRESS
2309 SHOREFIELD RD WHEATON MD 20902 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
March 27, 1985 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Maryland | | 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey
P.A., Rockville, Maryland 20850 | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAR 28 1985 | | 25b. REGISTRAR'S SIGNATURE
Julia F. [Signature] | | | |

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